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ABSTRACT

The final report describes the Michigan Physicians' Conference on Elder Abuse project. The project conference had four major content areas, including: a general introduction to the problem of elder abuse; clinical symptoms of abuse; legal issues; and referral and case management techniques. Training techniques included lectures, group discussion, question and answer sessions, slides, and videotapes. The project's purpose is to provide Michigan physicians with training to assist them in carrying out the requirements of a new legal mandate that requires physicians, like other health and social services workers, to report suspected cases of abuse, neglect, or exploitation of vulnerable adults, including the elderly, to the Michigan Department of Social Services Division of Adult Protective Services. Following a list of the program's policies there is a literature review which describes the research done (mostly in the 1980s) on elder abuse, including identifying those who need assistance, institutional abuse, services for the victims, the laws on abuse and neglect, and the physician's role in identifying and treating elder abuse and neglect. Finally, the development of the project's training program is outlined from site selections to training material development and evaluation. An appendix contains conference materials (brochures, flyers, maps, agenda, etc.), the conference evaluation questionnaire, and other materials. Contains 132 references. (GLR)

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MICHIGAN PHYSICIANS' CONFERENCE ON ELDER ABUSE

by
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FINAL REPORT
TO THE ADMINISTRATION ON AGING
HHS GRANT NO. 05AM9045/01
"STATEWIDE SHORT-TERM TRAINING
AND CONTINUING EDUCATION
FOR PHYSICIANS ON ELDER ABUSE"
Co-Principal Investigators:
Mary C. Sengstock, Ph.D.
James G. O'Brien, M.D.
Date of Report: May 31, 1990

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PROJECT ABSTRACT

In December, 1987, the State of Michigan revised its laws regarding the abuse, neglect, and exploitation of vulnerable adults, including the elderly. The new law required that physicians, like other health and social services workers, report suspected cases of abuse, neglect, or exploitation of vulnerable adults, including the elderly, to the Michigan Department of Social Services division of Adult Protective Services.

This project, undertaken by Wayne State University, Michigan State University, the Michigan State Medical Society, and the Michigan State Office of Services to the Aging, and funded through a grant from the Administration on Aging, undertook to provide Michigan physicians with training to assist them in carrying out the requirements of this new legal mandate. Physicians are in a particularly critical position to observe elder abuse and neglect, and frequently have more resources than other professionals to assist victims of abuse, since they are more likely to see elderly persons, and are more likely to be trusted by them.

Literature on the problem of elder abuse has proliferated in the decade of the 1980s. This interest has included research studies (Block & Sinnott, 1979; Douglass et al, 1980; Sengstock & Liang, 1982), articles in professional publications (Burston, 1975; Palincsar & Cobb, 1982; O'Malley et al., 1983; O'Brien, 1986a; Friedman, 1983) as well as attention in the popular press (Robinson, 1985). It has also lead to attention from the political sector (Robinson, 1985; Pepper & Oaker, 1981, 1985; US HHS, 1985), and more recently, on attempts to obtain accurate data on the incidence of abuse in the aged population (Tatara, 1989). This research suggests "a rate of 32 maltreated elders per 1000" (Pillemer and Finkelhor, 1988: 53).

Training materials based on this literature were developed and adapted for use in training physicians. These constituted the "Michigan Physicians' Conference on Elder Abuse," which was presented in 5 cities located across the State of Michigan.

Four major content areas were delineated, including: a general introduction to the problem of elder abuse; clinical symptoms of abuse; legal issues; and referral and case management techniques. Training techniques included lectures, group discussion, question and answer sessions, slides, and videotapes.

Most attendees seemed well satisfied with the training materials, giving them an average rating of "very good." Most also indicated that they thought their practices would change at least somewhat, as a result of the training.

Materials from the training have also been presented at various Conferences and meetings, such as the annual convention of the Michigan State Medical Society. The Principal Investigators also plan to develop a Physicians' Manual on Elder Abuse, and to make the training materials available through the Office of Medical Education Research and Development (OMERAD) at the Michigan State University College of Human Medicine.

EXECUTIVE SUMMARY

In December, 1987, the State of Michigan revised its laws regarding the abuse, neglect, and exploitation of vulnerable adults, including the elderly (Michigan, 1987). Prior to that time, Michigan law had mandated that health and social service workers report suspected abuse, neglect, or exploitation of vulnerable adults to the Michigan Department of Social Services division of Adult Protective Services (Michigan, 1983). Physicians, however, had been exempted from that law, with the provision that they should make a report of such suspected abuse if they felt it was in the best interests of the patient.

This exemption had created serious problems, resulting in the 1987 passage of the revision eliminating the distinction between physicians and other health and social service workers. Consequently, the time seemed appropriate for the development of training for physicians, making them aware of the new legal requirements, and introducing techniques for identifying and managing cases of abuse, neglect, and exploitation.

Responding to this need, the present authors, representing Wayne State University and Michigan State University, and working with the Michigan State Medical Society and the Michigan State Office of Services to the Aging, developed and submitted a proposal to the Administration on Aging, United States Office of Human Development Services, Department of Health and Human Services, for funding to develop and present such training to physicians throughout the State of Michigan. Funding was received, commencing in September, 1988, and continuing through April, 1990.

Materials were developed and adapted for use in training physicians, and the "Michigan Physicians' Conference on Elder Abuse". was presented in 5 cities located across the State of Michigan. The present paper details the nature of these training materials and the process by which they were developed; the process of selecting the training sites and the nature of the presentations; as well as an evaluation of the training as a whole.

Literature on the problem of elder abuse has proliferated in the decade of the 1980s. This interest has included research studies (Block & Sinnott, 1979; Douglass et al, 1980; Sengstock & Liang, 1982), articles in professional publications (Burston, 1975; Palincsar & Cobb, 1982; O'Malley et al., 1983; O'Brien, 1986a; Friedman, 1983) as well as attention in the popular press (Robinson, 1985). It has also lead to attention from the political sector (Robinson, 1985; Pepper & Oaker, 1981, 1985; US HHS, 1985), and more recently, on attempts to obtain accurate data on the incidence of abuse in the aged population (Tatara, 1989). This research suggests "a rate of 32 maltreated elders per 1000" (Pillemer and Finkelhor, 1988: 53).

A major problem with assisting elderly victims of abuse, neglect, or maltreatment is locating the persons in need of assistance. As indicated above, there is considerable evidence that the majority of cases do not come to the attention of authorities (Pillemer & Finkelhor, 1988; Tatara, 1989). Even

victims who are regularly seen by health and social service agencies may not be recognized as victims of abuse for weeks or months (Sengstock & Barrett, 1981). Consequently, the development of techniques of identification, and training personnel in their use, is a major requirement. Existing measures include short protocols designed to identify persons at risk (Hwalek & Sengstock, 1986, 1987), as well as comprehensive measures designed to document the symptoms of various types of abuse (Sengstock & Hwalek, 1986a).

Research has suggested a variety of services which might be useful in cases of elder abuse. A major complication, however, in resolving the problem of elder abuse results from the lack of availability of services which may be needed by its victims. Some services, such as police protection, have been found not to be available to many victims (Sengstock & Hwalek, 1986c). And many service providers lack training or experience in dealing with elder abuse.

As information about elder abuse has come into the news, pressure has been exerted upon politicians to take action to protect aged persons from being victimized by abusive behavior. Nearly all states have now passed laws which attempt to deal with elder abuse and neglect (Salend et al, 1984; Traxler, 1986; Thobaben, 1989). By far the most common response is a mandatory reporting law, which requires professionals working with the elderly to report suspected cases of elder abuse and/or neglect to a designated state agency (Quinn & Tomita, 1986: 228).

Michigan's elder abuse statute is an example of such a mandatory reporting statute, requiring professionals to report suspected cases of elder abuse, neglect, and endangerment which they observe in "vulnerable adults," which includes elders, as well as younger infirm persons, who may be in need of protection (Michigan, 1983). It provides reporters with protection against suits or prosecution by a disgruntled client or family member.

Physicians are in a particularly critical position to observe elder abuse and neglect, and frequently have more resources than other professionals to assist victims of abuse. Research has shown that more than one-fourth of physicians have encountered abuse or neglect, and another 20% had suspected abuse but were unable to verify it (O'Brien, 1988a). Consequently, it appears that the physician-patient setting is a particularly promising one for the identification and management of elder abuse, neglect, and maltreatment.

The physician is the only professional whom most elderly persons see on a regular basis; elderly people are particularly trusting of physicians, as compared with other professionals; physicians alone have access to key tests which may be needed to document abuse or neglect. Physicians should also be concerned about abuse because of the deleterious effects which abuse can have on the treatment programs which they develop for their patients. Treatment plans can have little effect if the patient is prevented by abuse, neglect, or financial exploitation from obtaining proper nutrition or needed medications.

In addition to the sponsoring organizations, the project also

involved the Geriatric Assessment Center at St. Lawrence Hospital, which provided consultation services on the management of elder abuse cases, and SPEC Associates, responsible for project evaluation. Legal advice was provided by attorneys familiar with elder abuse law. And representatives of the State Department of Social Services, which is responsible for receiving the mandated reports of abuse, were also involved. An Advisory Committee of key consultants to the project was established.

Every effort was made to insure that members of the medical profession would be included in all aspects of the planning and execution of the training conferences. It was important that there be no appearance that outsiders were attempting to train members of a profession other than their own.

Selection of appropriate locations for the training, and notifying Michigan physicians of its availability were important tasks in the early stages of the project. Training was planned for 6 sites throughout the State, distributed to cover the following areas: Upper Peninsula; Northern Lower Peninsula; South Central Michigan; and the Detroit area. One conference was eventually cancelled due to lack of enrollment.

The experience of the project lead to the conclusion that the timing and location plays a very important role in the success of training of physicians. The success of a training project can be doomed at the start if incorrect decisions are made in these areas. It is important to analyze the local community and the special characteristics of the medical profession in the community in selecting locations and dates for training. For example, we found it was important to consider which day of the week is the "traditional" day for medical in-service training in each community, an issue which varied greatly from one part of the State to another. We also found that some communities could easily be combined for training, while other communities, though located near each other, rarely come together for professional purposes. It is also to select a site which has high prestige in the community and which shares the dominant community values.

Even with the best of preparations, attendance at most of the conferences was poor. One of the most effective publicity techniques appeared to be direct mail to physicians; unfortunately, our budget did not permit a direct mailing to the entire Michigan State Medical Society. Publicity directed toward the aging population, in the hope that they would inform their physicians of the conferences, did not prove to be effective.

One problem which developed in the public relations area occurred with reference to the need to charge for the training, a requirement established In our original agreement with the Administration on Aging. This was particularly problematic in view of the fact that information about elder abuse is an area which the vast majority of physicians do not consider an issue which is necessary or desirable for them to understand. Requiring them to pay for such training is counterproductive.

Our most effective publicity efforts, by far, were those which were carried out for us by personnel in the local areas in which

the training was held. Such efforts add the support of the local community to the training.

Since the one day physician training conferences did not prove to be a very effective method of reaching physicians, other techniques of reaching physicians might be attempted. These include modification of the training to fit into shorter time periods for presentation to hospital staff during a series of lunch hour seminars or at meetings of professional societies.

The development of training materials appropriate for presenting the problem of elder abuse and neglect to physicians was the central focus of the project. Four major content areas were delineated:

1) A general introduction to the problem of elder abuse included the definition and types of elder abuse; magnitude of the problem; suggested causes of abuse and neglect; and other problems which may be correlated with abuse; and the physician's unique role in identifying and managing cases of abuse and neglect of the elderly.

2) Clinical symptoms of abuse focused on the clinical manifestations of abuse and neglect; techniques for detecting abuse and/or neglect in clinical settings; methods of distinguishing symptoms of abuse or neglect from the characteristics of normal aging; and important clinical tests which may help to formulate these distinctions.

3) The legal dimension provided an explanation of Michigan's mandatory reporting law for abuse and neglect of the elderly, with specific consideration of the manner in which it applies to physicians, together with the legal protections for those who report abuse, and other related legal issues.

4) Referral and case management provided physicians with information on the manner in which cases of elder abuse and neglect may be managed in the medical setting, including referrals for abuse victims and their families, and interfacing with Adult Protective Services, the agency which receives reports of abuse.

Materials were presented under several modes, including lectures, group discussion, question and answer sessions, and various types of visual materials, such as slides and videotapes. Slides were used where we wished to use provide photographic documentation of types of abuse and methods for identifying them. Videotapes, which provide a more dynamic perspective than slides, were used where we wished to demonstrate a process, such as the process of interviewing a patient or family member, or obtaining a case history from a patient. Three videotapes were developed, focusing on techniques of clinical identification, legal issues, and techniques of approaching an alleged offender or family member about the mandatory report to Adult Protective Services.

The Principal Investigators served as the major trainers and developed most of the training materials. Supplemental trainers were sought, however, for certain key areas, specifically, the legal issues, case management and referrals, and procedures of the Adult Protective Services division of the State Department of Social Services.

We were pleased to learn that the attendees seemed extremely well satisfied with the training materials which were developed. On a scale in which 1.00 represents "poor," and 5.00 represents "excellent," the session overall received an average rating of 4.08, which represents an overall rating of "very good." The Legal Issues lecture was particularly well received, receiving a rating of 4.42. Most respondents also indicated that they thought their practices would change at least somewhat, as a result of the training.

During the latter months of the project, both Principal Investigators appeared at various Conferences and meetings, making presentations in which all or part of the content was derived from the materials developed by the project. These included a presentation at the annual convention of the Michigan State Medical Society; Medical Grand Rounds at the University of Hawaii; a presentation to medical staff and residents at St. Lawrence Hospital during weekly staff training; and the Annual Family Care Conference, cosponsored by the Michigan State University Family Care Studies and College of Nursing and the Michigan State Office of Services to the Aging.

Future dissemination is planned in three areas. These include the development of an Physicians' Manual on Elder Abuse, which will be a concise description of the procedures for identifying, reporting, and managing a case of elder abuse or neglect; a modified version of this Physician Manual to be prepared for Physician Update, a publication of the Michigan State Medical Society; and the development of a training program containing the outlines, slides, and videotapes developed by the project. This program will be developed and marketed in conjunction with the Office of Medical Education Research and Development (OMERAD) at the Michigan State University College of Human Medicine.

POLICY/PROGRAM IMPLICATIONS: SUMMARY

1. Photographs developed for training medical personnel, including physicians, should not be selected for shock value. Rather they should be focused primarily on the identification of abuse or neglect in its early stages.
2. Audiovisual materials should be adapted to the material to be illustrated: videotapes for dynamic process, slides for depicting static contrasts.
3. The use of individual case histories in training physicians and other clinical professionals is one of the most valuable teaching tools available.
4. All materials to which reference is made in presentations should be made available to the Conference audience.
5. Considerable time for questions and answers between speakers and audience should be allotted.
6. As far as possible, training should be conducted by members of the profession being trained. Other professionals should be used only where their specific expertise is required.
7. Conferences should be open to a broad range of interested personnel, not limited to a single profession.
8. Training programs should follow local culture as much as possible, both in terms of practical issues such as conference timing, and community status and values.
9. Publicity for professional training will be most effective when channeled through the profession's own resources.
10. The support of a local organization is critical to the success of a training program.
11. When an area of professional training is one which members of the profession are not convinced of the value of an area of training, there should be no charge for the training. In fact, techniques should be developed to entice the members to attend.
12. Training programs may be more effective if they occur at the behest of a local institution. Such programs should be available to hospitals, possibly through a university or medical society.
13. Training programs for physicians should be scheduled such that the minimum amount of time is taken from the medical practice. Programs can be divided such that they require only one hour per week, extended over several weeks or months.
14. Training programs will probably be more successful in attracting professionals if held in conjunction with the profession's annual convention.
15. Materials on critical medical issues can be used more effectively if packaged in such a manner that they are no longer dependent upon the original developers, but can be used by other professionals for the conduct of in-service training.
16. Critical information on issues such as the identification and management of elder abuse might reach more physicians if serialized in the major professional journals.
17. Concise descriptive materials which can be kept easily at hand may be more valuable training for physicians than conferences which occur in isolation.

INTRODUCTION

In December, 1987, the State of Michigan revised its laws regarding the abuse, neglect, and exploitation of vulnerable adults, including the elderly (Michigan, 1987). Prior to that time, Michigan law had mandated that health and social service workers report suspected abuse, neglect, or exploitation of vulnerable adults to the Michigan Department of Social Services division of Adult Protective Services (Michigan, 1983). Physicians, however, had been exempted from that law, with the provision that they should make a report of such suspected abuse if they felt it was in the best interests of the patient (Michigan, 1983).

Interviews with hospital personnel and Adult Protective Service workers indicated that this provision in the mandatory reporting law had created serious problems for physicians, hospitals, and health and social workers. Dilemmas developed when personnel encountered a case in which they suspected abuse or neglect. Nurses and social workers knew that they were mandated, under Michigan law, to make a report, but the physician in charge of the case felt it was not "in the best interest of the patient," and did not want the abuse reported. Hospitals eventually became concerned over these conflicts of responsibility, and responded by developing policies indicating which regulation should govern such occurrences in the hospital.

This controversy culminated in the 1987 passage of the revision to the Michigan mandatory reporting law. Under this

revised code, there no longer was a distinction between physicians and other health and social service workers. Physicians were mandated to report on the same basis as other health and social service professionals. Many physicians in practice were not aware of this new provision in the law, however. This is not surprising, in view of the fact that physicians have not generally been aware of the existence of laws governing the reporting of abuse, neglect, and maltreatment (O'Brien, 1988). Consequently, the time seemed appropriate for the development of training for physicians, making them aware of the new legal requirements, and introducing techniques for identifying and managing cases of abuse, neglect, and exploitation.

Responding to this need, the current authors, working with the Michigan State Medical Society and the Michigan State Office of Services to the Aging, developed and submitted a proposal to the Administration on Aging, United States Office of Human Development Services, Department of Health and Human Services, for funding to develop and present such training to physicians throughout the State of Michigan. Funding was received, commencing in September, 1988, and continuing through April, 1990.

Materials were developed and adapted for use in training physicians, and the "Michigan Physicians' Conference on Elder Abuse" was presented in 5 cities located across the State of Michigan. The present paper details the nature of these training materials and the process by which they were developed; the process of selecting the training sites and the nature of the

presentations; as well as an evaluation of the training as a whole.

Since the focus of this project was specifically on abuse, neglect and exploitation of the elderly, as opposed to all vulnerable adults, references throughout the remainder of this report will focus solely on abuse of the elderly, rather than on adult abuse in general. Furthermore, in the interest of brevity, the term, "abuse," will be used as a generic term, to refer to all types of abuse, neglect, and exploitation of the elderly. Where we intend to refer to a specific type of abuse, it will be so noted.

PART I

REVIEW OF THE LITERATURE

Initial Studies:

Discussion of the problem of elder abuse has proliferated in the decade of the 1980s. This interest has included research studies (Block & Sinnott, 1979; Douglass et al, 1980; Sengstock & Liang, 1982), articles in professional publications (Burston, 1975; Palincsar & Cobb, 1982; O'Malley et al., 1983; O'Brien, 1986a; Friedman, 1983) as well as attention in the popular press (Robinson, 1985). It has also lead to attention from the political sector (Robinson, 1985; Pepper & Oaker, 1981, 1985; US HHS, 1985).

The earliest studies focused largely on cases of elder abuse which had already become known to social agencies (Block & Sinnott, 1979; Lau & Kosberg, 1979; Douglass et al., 1980; Hickey & Douglass, 1981a,b; Sengstock & Liang, 1982, 1983). A major advantage in such studies was that they documented the existence of abuse and neglect of the elderly. They also served to clarify the various forms which elder abuse can assume, and to suggest some of the characteristics which surround the problem of abuse.

The types of abuse identified have varied from study to study, but most tend to agree that they include most, if not all, of the following actions: direct physical assault; sexual assault; neglect of the physical needs of the aged person; neglect of the elder's psychological needs; psychological abuse (which includes verbal assault, belittling or demeaning comments); financial or material abuse (the theft or misuse of an elder's property); and

the violation of the rights of the elder (Sengstock & Hwalek, 1987).

Studies vary, however, on the issue of the relative frequency of each type of abuse. Depending upon the population studied, some research has concluded that physical abuse is the most frequent type (Lau & Kosberg, 1979); while others have found the most frequent type to be neglect (Douglass et al., 1980; Hickey & Douglass, 1981a,b); and still others have found psychological abuse (Block & Sinnott, 1979) or financial abuse to be the most frequent (Sengstock & Liang, 1982, 1983).

In large part, the type of abuse most frequently found was related to the types of agencies which the study surveyed. For example, one study which focused on the cases seen in a medical setting found physical abuse to be most frequent (Lau & Kosberg, 1979); a study which interviewed primarily social workers found psychological abuse to be most common (Block & Sinnott, 1979); and a study which found numerous cases of financial abuse had analyzed a number of cases from a legal aid agency (Sengstock & Liang, 1982, 1983).

Another contribution of these early studies was the delineation of various factors which appeared to be related to elder abuse and neglect. Block & Sinnott (1979) suggested several characteristics which help to promote elder abuse. These include: demographic changes which have occurred in society, such as the extension of life expectancy and the smaller number of children to provide care; economic issues, such as the high cost of medical

care; changes which occur in the lives of both the elder and their adult children, making elder care difficult; the tensions which inevitably occur with three generational living; and the fact that many families may have had unsatisfactory relationships long before the problems of care-giving occurred.

Hickey and Douglass (1981a,b) found that the infirm elderly are more likely to be abused, and emphasized the tensions which develop when families attempt to provide long term care to a dependent family member. Sengstock and Liang (1982, 1983) found that abuse, particularly financial abuse, can occur even with healthy elders. They also found a relationship between the type of abuse identified and the specific focus of the agency identifying the abuse; i.e., medical agencies were more likely to identify physical abuse; home health care agencies to identify neglect; legal agencies to identify financial abuse, and so on.

These early studies also illustrated the widespread character of elder abuse, noting that abuse was to be found among elders of a variety of racial groups, social classes, religious backgrounds, and the like (Sengstock & Liang, 1982, 1983). Studies differed, however, on the most likely abusers. Block & Sinnott (1979), for example, found that daughters were the most likely abusers, while Sengstock & Liang (1982, 1983) found that about half of their cases were the children of the victims, with sons and daughters equally likely to be the perpetrator. Contrary to assumptions that abused or neglected elders tend to be a drain on the family finances, Wolf et al. (1984) found that the abuser was likely to be financially

dependent on the victim.

Incidence of Elder Abuse and Neglect:

Such studies, however, since they focus on cases which have already been identified by health and social agencies, cannot provide any data on the incidence of abuse in the aged population. Studies of known cases provide no information about the cases which may exist in the community, but have, as yet, remained hidden from public view. Consequently, a recent focus of research has been the attempt to obtain accurate data on the incidence of abuse in the aged population (Pillemer & Finkelhor, 1988; Tatara, 1989).

One is tempted to look to the formal reports of abuse and/or neglect as a source of information on the incidence of cases of maltreatment of the elderly, since such information is routinely collected in nearly all states, and represents the largest volume of data on abuse and neglect of the elderly currently available. One study attempts to collect and use these data to develop rates of incidence for each state, for groups of states with different reporting mechanisms, and finally, for the nation as a whole (Tatara, 1989).

This research bears the same restrictions as the earlier studies, however. Although the actual numbers of cases studied may be substantially greater, the representativeness of the sample of cases is still in question, since it is widely recognized that a large proportion of the cases of elder abuse and neglect probably go unreported. One study suggests that only 1 case in 14 comes to

public attention (Pillemer & Finkelhor, 1988). Consequently, even the author of this study recognizes this limitation (Tatara, 1989: 164).

In the first attempt to conduct a random sample survey of elder abuse, Pillemer and Finkelhor (1988: 53) found "a rate of 32 maltreated elder per 1000." Contrary to the findings of earlier studies, they found the most common perpetrators of abuse to the spouses of the elderly victims. They also found that elderly males exhibited a higher rate of victimization than elderly females, a surprising pattern in light of the preponderance of female victims in earlier studies.

However, the Pillemer and Finkelhor study is limited in its application, in that it studies only the Boston, Massachusetts, metropolitan area (Tatara, 1989). Furthermore, the study included only three of the types of abuse usually included in the categories, as listed above (physical abuse, psychological abuse, and neglect). Finally the method of selecting the sample leads one to wonder whether the study may not have undercounted that segment of the elderly who may be living with children or other relatives.

Identification of Elder Abuse and Neglect:

A major problem with assisting elderly victims of abuse, neglect, or maltreatment is locating the persons in need of assistance. As indicated above, there is considerable evidence that the majority of cases do not come to the attention of authorities (Pillemer & Finkelhor, 1988; Tatara, 1989). Even

victims who are regularly seen by health and social service agencies may not be recognized as victims of abuse for weeks or months (Sengstock & Barrett, 1981). Elders who have not been identified as victims of abuse or neglect cannot receive the assistance they need. Consequently, the development of techniques of identification is a major requirement.

Many agencies have developed their own techniques for the identification of elderly victims of abuse. These include clinical techniques for use in hospital and agency settings, identification procedures for use in state protective services departments, as well as measures for use in research (Sengstock & Hwalek, 1985/86; Sengstock & Hwalek, 1987). Analysis of the early techniques suggests that they had many flaws, including: the inclusion of items which measured more than one type of abuse; requiring observers to make multiple judgments, such as observing the presence of abuse as well as determining the deliberateness of the act; and the omission of some types of abuse, particularly sexual assault (Sengstock & Hwalek, 1985/85). Measures include short protocols designed to identify persons at-risk (Hwalek & Sengstock, 1986, 1987), as well as comprehensive measures designed to document the symptoms of various types of abuse (Sengstock & Hwalek, 1986a). The validity of such measures in identifying abuse and neglect remains untested, however.

Institutional Abuse:

Another issue of concern has been the abuse of elders confined

to institutions such as nursing homes or long term care facilities (Select Committee, 1985). Abuse, neglect, and exploitation of the elderly in institutionalized settings is a widely discussed problem, but empirical research and professional journal articles on the subject are limited. There is considerable evidence that the care provided in institutions is frequently low in quality (Bragg et al., 1978-79; Himmelstein et al., 1983; Kimsey et al., 1981).

The extent of the problem remains an enigma, however. The elder abuse literature focuses primarily on domestic settings (Block & Sinnott, 1979; Hickey & Douglass, 1981; Sengstock & Barrett, 1984; Sengstock & Liang, 1983). The only epidemiological attempt to gauge the incidence of elder abuse also focused only on community dwelling elderly (Pillemer & Finkelhor, 1988).

Institutionalized abuse is a critical problem for social attention because of the nature of the group in question. Elders who are institutionalized are a particularly vulnerable group who often do not or cannot complain even when abused. Kimsey et al. (1981) speculate that the elderly do not complain about abuse because of fear of retaliation by formal caretakers. They may be threatened with discharge from the home or with possible further abuse in any of a variety of ways. There has also been speculation that the elderly are ignorant of their rights and legal remedies.

Elders themselves may be apathetic because of physical and/or cognitive deterioration and accept their lot and become defeated, helpless and depressed (Kimsey et al., 1981). In addition, the

institutionalized elderly are usually poor and lacking in social support (Bragg et al., 1978-79).

Part of the difficulty in developing sufficient data on elder abuse in institutional settings is the lack of measurement instruments targeted to identifying institutional abuse. Elder abuse measures presently in use have generally been developed for use in community-based settings, or in acute care hospitals (Block & Sinnott, 1979; Cash, 1982; Hooyman & Tomita, 1982; Johnson, 1981; Shell, 1982; Sengstock & Hwalek, 1985; Hwalek & Sengstock, 1985a). Yet the development of measures specifically adapted for use with an institutionalized population could be of considerable value to families, patient rights organizations, and licensing agencies, as they endeavor to evaluate the level of care received by patients. One such measure has recently been modified to make it useful in institutional settings (Sengstock & Hwalek, 1985; Sengstock et al., 1990).

Services for Victims:

Another topic which has received far too little attention concerns the services which are provided to victims of elder abuse. Few communities have developed special services specifically targeted at victims of elder abuse or neglect. Rather, they tend to receive the types of services which are available to other elders in the community, although they may receive varying types of services depending upon the type of abuse and other characteristics of the victim. Clients who were victims of self-

neglect were also found to receive more services than victims of abuse or neglect by someone else (Sengstock et al., 1989). This suggests that service workers are still unfamiliar with working with direct abuse cases; therefore they concentrate their efforts on those cases with which they are more familiar and over which they have greater control.

Research has suggested a variety of services which might be useful in cases of elder abuse. Among these are in-home social work (Kinderknecht, 1986); legal assistance (Sengstock & Barrett, 1986); inpatient psychiatric services (Lau, 1986); and crisis intervention, counseling, and support services both for the victim and for the family (Kinney et al., 1986).

Service providers also distinguish between services which must be provided immediately and those which should occur on a longer term basis. In the former category are obtaining treatment for injuries and removing the victim and his/her assets from the control of the abuser (Quinn & Tomita, 1986: 140-151). Experienced professionals suggest that long term case management or monitoring is particularly useful in abuse cases, as are strategies to reduce caregiver stress; it may also be necessary to alter the living situation of the victim (Haviland & O'Brien, 1989; Quinn & Tomita, 1986). It has also been noted that each elderly abuse victim usually requires a wide variety of services, and that these should be integrated into a comprehensive, unified whole (Wolf et al, 1985-6; Conley, 1986).

A major complication, however, in resolving the problem of

elder abuse results from the lack of availability of services which may be needed by its victims. Some services, such as police protection, have been found not to be available to many victims (Sengstock & Hwalek, 1986c). Funding mechanisms often exclude certain types of services or make them available only after establishing financial need. Many services are unavailable in some communities (Kinderknecht, 1986). Service provision is also complicated by agency fragmentation (Emlet, 1984). And many service providers lack training or experience in dealing with elder abuse, having been trained prior to the recognition of this problem. This is a special difficulty for new workers, or those who handle only an occasional case of elder abuse.

In an attempt to improve services for abused and neglected elders and provide guidance to workers, some social and governmental agencies have developed new models for the delivery of services to the elders and their families (Traxler, 1986). The value of such theoretical service models is not entirely clear, however. In some instances, new service models have resulted in improved services (Emlet, 1984). In others, the initial promise of a new service model has not been borne out over time (Kallen, 1984).

In an earlier article, we provided an analysis of the manner in which services to elder abuse victims varied with the type of abuse from which they suffered (Sengstock et al., 1990). In the present paper, our attention is focused on the theoretical model under which services are provided to the elderly victims. We will

review the types of services provided, as well as the case worker's assessment of the case outcome, in elder abuse cases handled under two different types of theoretical service models. The nature of the service models and the data collected will be provided in the two sections which follow.

Laws on Abuse and Neglect:

As information about elder abuse has come into the news, pressure has been exerted upon politicians to take action to protect aged persons from being victimized by abusive behavior. Nearly all states have now passed laws which attempt to deal with elder abuse and neglect (Salend et al, 1984; Traxler, 1986; Thobaben, 1989). By far the most common response is a mandatory reporting law, which requires professionals working with the elderly to report suspected cases of elder abuse and/or neglect to a designated state agency (Quinn & Tomita, 1986: 228). These laws proliferate even though experts who work with elder abuse on a regular basis are still uncertain as to their value in preventing elder abuse or alleviating its symptoms.(Faulkner, 1982; Quinn & Tomita, 1986; Sengstock, 1988).

In fact, workers who encounter elder abuse on a regular basis often find that mandatory reporting statutes may present additional barriers to them as they attempt to provide assistance to clients who are victims of abuse. Included are the complaint that reporting is required even though no services may be available to deal with the abuse, or that the agency authorized to receive the

reports has no additional personnel or funding to handle the investigations (Quinn & Tomita, 1986; Sengstock, 1988). In addition, elder abuse statutes usually guarantee autonomy to the elder in determining whether or not to accept assistance for his/her plight (Michigan, 1983; Illinois, 1983). Consequently, it is difficult to justify required reporting, when the client has indicated that s/he does not intend to accept assistance if the report is made. In such cases the report may only damage the rapport which the reporting professional has already developed with the client, resulting in less rather than more assistance.

On the other hand, mandatory reporting statutes have some clear advantages. Proponents contend that these statutes allow professionals in intervene more quickly in situations of endangerment, in which a mentally or physically handicapped elder is either incapable of protecting him/herself, or too frightened to do so (Quinn & Tomita, 1986. Another advantage, from the standpoint of professionals, is the protection which such statutes offer to the reporting individual. Under mandatory reporting laws, the professional can explain to the client and/or family that s/he is required to report a suspicious situation and has no alternative, alleviating pressure from clients or patients who may want to avoid public knowledge of the situation (Sengstock, 1988). Such laws usually provide protection from civil suit for the professional who reports in good faith (Michigan, 1983).

Michigan's elder abuse statute exhibits all of the characteristics, both advantages and disadvantages, listed above.

It is a mandatory reporting statute, requiring professionals to report suspected cases of elder abuse, neglect, and endangerment which they observe in "vulnerable adults," which includes elders, as wel as younger infirm persons, who may be in need of protection (Michigan, 1983). It provides reporters with protection against suits or prosecution by a disgruntled client or family member. It did not, however, provide any extra funding to the Michigan Department of Social Services, the agency mandated to receive the reports, for either investigative costs or services.

As indicated previously, the original mandatory reporting statute exempted physicians from reporting if they believed it was not in the best interests of the patient. Although physicians had originally sought the exemption from the reporting statute, it soon became obvious that the variant reporting requirements for different professionals, who frequently were working together on the same case, presented serious problems. Nurses, medical social workers, and other health professionals working on a case were obligated, under the requirements of the mandatory reporting law, to report suspected abuse they observed. At the same time, the physician in charge of the case might believe it to be in the "best interest" of his/her patient not to report the suspected abuse.

This conflict of requirements forced many hospitals to develop institutional policies specifying the procedures to be followed in the event of a disagreement. Many hospitals chose to support their staff members observance of the legal requirement to report, even if the attending physician disagreed. In recognition of these

difficulties, the revised statute, enacted with the cooperation of the Michigan State Medical Society, amended the original requirement to mandate reporting from physicians on the same basis as other professionals (Michigan, 1987).

The Physicians' Role in Identifying and Treating Elder Abuse and Neglect:

Physicians are in a particularly critical position to observe elder abuse and neglect, and frequently have more resources than other professionals to assist victims of abuse. Research has shown that more than one-fourth of physicians have encountered abuse or neglect, and another 20% had suspected abuse but were unable to verify it. This was true in spite of the fact that most physicians have not been trained to identify abuse or neglect, and that most had no routine procedures for identifying these problems. Physicians also exhibited a lack of knowledge of the reporting requirements of their states. Although the states studied (Michigan and North Carolina) both had requirements for reporting and intervening in cases of abuse, about three fourths of the responding physicians were unaware of these requirements. At the same time, over half of the physicians reported that they were willing to become involved in helping the abuse victims, that they treated the victims' families as well, and that they believed the victims and their families would be willing to accept help (O'Brien, 1988a). Consequently, it appears that the physician-patient setting is a particularly promising one for the

identification and management of elder abuse, neglect, and maltreatment.

Conclusion:

The amendment to Michigan's mandatory reporting law is particularly valuable in view of the fact that physicians play an especially important role in dealing with the problem of elder abuse and neglect. This special role stems from several factors. First, physicians are the only professional whom most elderly persons see on a regular basis; consequently, they are in a unique position to identify victims who may never be observed by social workers or nurses. Second, elderly people are particularly trusting of physicians, as compared with other professionals; even if they are reluctant to trust embarrassing information to outsiders, they are more likely to trust a physician with this information than any other professional.

Third, physicians alone have access to key tests, such as X-rays or blood tests, which may be needed to document abuse or neglect; in this respect, they are also needed as resources for other professionals who may deal with abuse or neglect cases. Finally, physicians should be concerned about abuse because of the deleterious effects which abuse can have on the treatment programs which they develop for their patients. Laboratory tests and medications can have little effect if the patient is prevented by abuse, neglect, or financial exploitation from obtaining proper nutrition or needed medications.

PART II

PROJECT ORGANIZATION AND STRUCTURE

The physician training project was a cooperative venture cosponsored by two state universities which are located in two different cities, as well as the Michigan State Medical Society, and the Michigan State Office of Services to the Aging. Under auspices of the project, conferences were presented in several cities scattered throughout the entire State. In addition to the sponsoring organizations, the project also involved the Geriatric Assessment Center at St. Lawrence Hospital, which was providing consultation services on the management of elder abuse cases, and SPEC Associates, responsible for project evaluation. The specific responsibilities of each organization will now be delineated.

Responsibilities of Component Organizations:

As the major sponsoring institution, Wayne State University was responsible for the major management of the project. This included the administrative and financial management of the project and its personnel, as well as providing the services of Dr. Sengstock, one of the two Co-Principal Investigators. A major contribution of Wayne State University to the project was Dr. Sengstock's time during her Sabbatical leave, Winter term, 1989. This leave allowed Dr. Sengstock to devote full time to the development of training materials at no expense to the project.

Other contributions of the University included resources for the publication of brochures and the use of resources of the

Sociology Department, in which the project was housed, committed the use of its resources for telephone, photocopying, typing, etc. In addition, the School of Medicine provided support through its contacts with hospitals and physicians in the Detroit Metropolitan Area, and the Institute of Gerontology served as a means of access to other professionals interested in the area of gerontology.

Michigan State University, Dr. O'Brien's institution, contributed a portion of Dr. O'Brien's time to the project. The College of Human Medicine provided the majority of the audiovisual resources for the project, including the studios and technical personnel for videotaping and development of slides for the training. The administrative services for registering conference attendance and the payment of fees were also handled through the College of Human Medicine at Michigan State University; Ms. Mary Edna Helfer, Director of the Department of Continuing Education Programs of the College of Human Medicine, directed this operation for us. The College's contacts with hospitals and physicians throughout the rural sections of the State of Michigan were also useful in selecting training sites.

Dr. O'Brien is Director of the Geriatric Assessment Center at St. Lawrence Hospital, in Lansing, Michigan. This unit proved to be especially valuable to the project in a variety of ways. It provided office space to the project, allowing Dr. Sengstock and Mr. Goldynia a centralized place for meetings and the storage of project materials. Several members of the staff of the hospital as well as the Geriatric Assessment Center also provided valuable

consultant services to the project.

SPEC ("Social Programs Evaluators and Consultants") Associates was designated as the evaluators of the conferences. Dr. Melanie Hwalek, President of SPEC Associates, designed the evaluation questionnaire, served as a member of the Advisory Committee, tabulated the responses, and provided an analysis of the data from the evaluations.

Consultants:

In addition to the major participants, the project enjoyed the assistance of a number of other personnel as consultants.

Advisory Committee: An Advisory Committee was established, consisting of representatives from each of the institutions participating in the project, as well as other valuable consultants. The members, and their respective groups or organizations, were as follows: Dr. O'Brien and Dr. Sengstock, Principal Investigators, ex officio, on behalf of the two cooperating universities; Dr. Melanie Hwalek, Ph.D., President, SPEC Associates; Brooker L. Masters, M.D., Michigan State Medical Society; Olivia P. Maynard, Director, Office of Services to the Aging (Alternate: Sally Grady); Rhonda Montgomery, Ph.D., Director, Wayne State University Institute of Gerontology (Alternate: Elizabeth Olsen, Ph.D.); Thomas Trainer, J.D., attorney specializing in legal problems of the aged; Paul Werner, M.D., Director of Geriatric Programs, Department of Family Medicine, Wayne State University.

The Advisory Committee met three times during the course of the project, providing assistance on a variety of issues. The initial meeting took place approximately three months after the commencement of the project. At this meeting, members of the Committee made suggestions related to the content of the training, possible training sites, as well as techniques for advertising the training and stimulating physicians to attend.

At the second meeting, held shortly before the first training conference, committee members heard reports on the training materials developed and the training locations selected. They discussed and made recommendations on the content and format of the conferences; plans for the development of videotapes and other audiovisual materials; the format for conference evaluation; and plans for publicity and the distribution of brochures. The Advisory Committee proved particularly helpful in making recommendations in the area of publicity and public relations with physicians.

The final meeting of the Advisory Committee was held following the completion of the series of training conferences. At this meeting members of the project staff summarized the results of the conferences. Committee discussion assisted in evaluating the outcome of the conferences and provided recommendations which are included in this report.

Other Consultations:

In addition to the formal participation of project staff and

Advisory Committee members, numerous other persons made their professional resources available to the project in a variety of ways.

Thomas Trainer, J.D., in addition to his assistance as a member of the Advisory Committee, served as chief legal consultant to the project. In this capacity, he provided background information on Michigan's laws regarding elder abuse and the legal aspects of mandatory reporting for physicians and other professionals in the State of Michigan. This consultation included the development of the lecture on elder abuse laws for the conference and presentation of this lecture at four of the five conferences, as well as assistance in the planning of the videotape on elder abuse laws and participation in the taping of the videotape.

Sharon Miller, J.D., another attorney with expertise in laws related to elder abuse and neglect, provided assistance when Mr. Trainer was unavailable.

Sue Haviland, R.N., and Leon Schrauben, M.S.W,, both of the Geriatric Assessment Center at St. Lawrence Hospital, provided input into the identification of abused elders, the management of cases involving elder abuse and neglect, and the types of services that victims and their families require. Together they developed the presentation on services and case management for the conference, and they assisted in conducting the presentations. They also assisted in the development of the videotape for the services and case management segment.

The project was fortunate in being able to obtain specialized consultations on the medical manifestations of abuse and the development of possible audio-visual materials to demonstrate them. Chief among these were Terri Boyd, an enterostomal nurse at St. Lawrence Hospital in Lansing, Michigan. Ms. Boyd provided copious information on the subject of appropriate skin care in cases of Physical Neglect, and the type of information which should be provided to physicians in this regard.

Dr. Sue Parkins and Ms. Julie Coyle, physician and social worker, respectively, at St. Vincent's Hospital in Toledo, Ohio, provided valuable information on the medical manifestations of abuse and neglect. They also shared with us information on the ways in which they use visual materials to demonstrate the identification and treatment of abuse and neglect.

Mary Noelle, Ph.D., a dietitian on the staff of the Department of Family Practice at Michigan State University, was consulted to provide dietary information which could be included in the physicians' materials.

Regarding the development of videotapes, we were fortunate to have the assistance of members of the Michigan State University staff who are knowledgeable in this area. Mr. John Williamson, with Medical Media Services of the Michigan State University College of Osteopathic Medicine, was responsible for the technical aspects of the videotape production. Ms. Karen Lienhart, M.A., a Specialist on Instructional Product Development with the Office of Medical Education Research and Development at the College of Human

Medicine, is assisting in the dissemination of materials from the project, a topic which will be discussed at a later point.

The Michigan State Department of Social Services, Division of Adult Protective Services, also provided assistance to the project. This office is responsible, under the provisions of the Michigan mandatory reporting law, for receiving and investigating reports of abuse, neglect, or maltreatment. Consequently, it seemed appropriate to include members of the staff of this department in the training conferences.

Mr. William Chaliman of the Michigan State Department of Social Services arranged for personnel from each of the local offices of this department to appear at each of the conferences. The Adult Protective Services presenters included the following: East Lansing Conference: Ms. Jan Baszler, Adult Protective Services work for Ingham County; Marquette Conference: Mr. Val White, Supervisor, and Mr. Randy Haddis, Adult Protective Services worker for Marquette County; Traverse City Conference: Ms. Cathy Hamilton, Adult Protective Services supervisor for Grand Traverse County; Kalamazoo Conference: Ms. Rebecca Moore, Adult Protective Services worker for Kalamazoo County; and Detroit Conference: Mark Nowakowski, Adult Protective Services worker for Wayne County. In addition, Ms. Jan Baszler, the speaker for the East Lansing Conference, also made a presentation on Adult Protective Services procedures for our videotape on case management.

We are grateful to each of these Adult Protective Services workers for their contribution to our Conferences. The presence

of these specialists allowed our Conferences the opportunity to present an overview of the statewide management of cases of abuse, as well as individualized information on the handling of cases in each localized area of the state.

Coordination of Project Activities:

As indicated earlier, this project was co-sponsored by two state universities which are located in two different cities, as well as the Michigan State Medical Society, and the Michigan State Office of Services to the Aging. Conferences were presented in several cities scattered throughout the entire State of Michigan. In addition, the project also involved St. Lawrence Hospital, SPEC Associates, and a wide variety of other consultants. Consequently, complex coordination issues commenced immediately, and remained a continuing concern of the project.

This coordination was accomplished through a variety of techniques. First, both Principal Investigators assumed joint responsibility for the conduct of all aspects of the project. Consequently, both Dr. Sengstock and Dr. O'Brien were well acquainted with all aspects of the project, and could substitute for each other whenever necessary.

Second, one Principal Investigator, Dr. Sengstock, assumed the responsibility of Project Director and was responsible for coordination of the activities of all persons involved in the project. In order to assure project coordination, the Project Director divided her time between the two major sites in which

project activities were located, spending 2 days each week in Lansing, the location of Michigan State University, the Michigan State Medical Society, the State Office of Services to the Aging, and St. Lawrence Hospital, and the remainder of the week in the Detroit area, the site of Wayne State University and SPEC Associates.

Third, there was a need for complicated contractual relationships between the major sponsoring organization, Wayne State University, and the other participating organizations, specifying the responsibilities of each organization and the method and amount of payment for these services. The Wayne State University Office of Research and Sponsored Programs was responsible for establishing these contractual relationships.

Fourth, a Research Assistant was hired for the project, whose major responsibility was to handle the routine matters involved in a project of this magnitude: communicating and coordinating between the two Principal Investigators, both universities, the other sponsoring and cooperating organizations, and various sites being considered for location of the conferences. This person had to be available to travel, not only between Detroit and Lansing, but also to the various training sites. The person selected for this position, Mr. Andrew M. Goldynia, held a Master's degree in speech communication, suiting him well for this coordination post.

Fifth, an Advisory Committee was appointed, including members from all of the participating organizations. The meetings of this committee, which will be described further at a later point, also

assisted in coordinating the activities of the various organizations and personnel.

Finally, specific clerical personnel at each participating institution were responsible for handling the numerous interchanges involved in the interrelationships between the institutions. These included such day to day issues as purchase of supplies, payment for travel, etc. This was probably the most troublesome aspect of the project, and things did not always run smoothly in these areas. More efficient and committed clerical personnel would have made the administration of the project much easier. On the other hand, several staff members went out of their way to be of exceptional help. Among these were: Ms. Jan Yonker and Ms. Carolyn Hylek of St. Lawrence Hospital Geriatric Assessment Center; Ms. Yvonne Thorne of the Sociology Department at Wayne State University; and, of course, our Research Assistant, Mr. Andrew M. Goldynia. Their indispensable aid enabled us to handle the problems which arose.

PART III

SITE SELECTION AND PUBLIC RELATIONS

Selection of appropriate locations for the training, and notifying Michigan physicians of its availability were the two most important tasks which the project faced in the early months. The most valuable training is of little value if it is provided in locations which are inaccessible or if the target population is unaware of its availability. Consequently, these two tasks were a serious concern during the initial stages of the project.

Site Selection:

As provided in the original proposal, the project was committed to providing training at four sites throughout the State of Michigan, to be located as follows: Upper Peninsula; Northern Lower Peninsula; South Central Michigan; and the Detroit area. (For the location of the planned conferences, see the map in Appendix A.).

A great deal of time and effort, particularly on the part of Mr. Goldynia, the Research Assistant, was spent on contacting hospitals and other agencies in these four general areas, attempting to secure sites and specific dates for the training sessions. We were pleased to discover that the idea of training physicians on the topic of elder abuse was very warmly received by the hospitals and medical centers which were contacted as possible training sites. Several hospitals have been willing, even anxious to host the training. This was particularly true of hospitals

involved with the Clinical Campuses of the Michigan State University College of Human Medicine.

We made considerable use of the advice of our Advisory Committee, in this respect. Discussions with Advisory Committee members, Brooker L. Masters, M.D., and Paul Werner, M.D., as well as Mr. Tom Plasman, staff member of the Michigan State Medical Society, provided us with valuable background information on the types of factors which should be considered in selecting the sites for training. Both the city and institution within the city had to be considered.

We had already planned to locate the training session at several locations throughout the State, such that physicians would not have to travel too far. However, we learned that physicians from some areas were accustomed to coming together for conferences, while other cities were very unlikely to do so. For example, physicians located throughout the sparsely populated Upper Peninsula of Michigan frequently come together for training and conferences. Hence a single conference in this area might be expected to draw from the entire area. On the other hand, in the central and western portion of the Lower Peninsula (section II of the attached map) physician relations tend to be highly localized. They are unlikely to go to neighboring areas for training, even though the distances are less than those in the northern sections of the State. Consequently, we were concerned that a single conference in this area of the State would be inappropriate.

Not only the city but also the institution within the city was

an important factor in selection. We were, of course, concerned with the cost of the facilities; several recommended facilities were conference centers with costly rental fees, which we wished to avoid. We were also warned, however, that the local reputation was an important factor to be considered. In a predominantly fundamentalist Christian or Catholic area of the State, for example, we should not select the only hospital performing abortions as the site of training. Preferably, we should attempt to schedule training at one of the higher prestige institutions of the community.

Not only the locations but also the day of the week had to be considered in scheduling training. Certain days are "traditional" days for medical conferences in certain cities. These are days on which physicians in these areas typically do not schedule office hours and are more likely to be available for training. On other days they were less likely to attend, since this would require canceling their normal time to see patients. We also learned that the "traditional" training days varied considerably from one community to another.

Hence we had to take care to insure that each training session was scheduled at the most opportune time for the community in which it was located. This sometimes created a problem in scheduling training, since we frequently found hospital space to be more easily available on the days of the week not usually used for training. We were fortunate to have the advice of our experts, since we might have chosen inappropriate days or training sites

without their input.

As a result of all of these issues, the project staff was persuaded to plan for training at six sites, rather than the original four. Three conferences were scheduled for the central and western portion of lower Michigan, where we believed it was unlikely that physicians would attend training outside of their immediate community.

The first session was scheduled for East Lansing in late June. This session, which was directed primarily toward faculty and students at the MSU clinical center, was planned as a rehearsal session. It was hoped that the presentation of the first session at Michigan State University would enable the members of the training staff to obtain a more effective response to their presentations from the MSU audience. We had considered making this a closed session, but it was decided that this conference, like all the others, should be available to physicians in the local community as well.

The Upper Peninsula session was scheduled for Marquette in mid-August, with the Northern Lower Peninsula conference scheduled for Traverse City in early September. Both were scheduled early in the conference schedule due to the unpredictability of weather in the northern portions of Michigan in the late fall and winter. Two more sessions were scheduled for late September and October in the Central and Western Lower Peninsula, with the final session scheduled for Detroit in November. All six sessions had to be conducted within the original budget constraints.

The final schedule of the conferences was as follows:

Michigan State University Clinical Center, Lansing, MI,
June 21, 1989 (South Central Michigan);

Marquette General Hospital, Marquette, MI,
August 11, 1989 (Upper Peninsula);

Munson Medical Center, Traverse City, MI,
September 9, 1989 (Northern Lower Peninsula);

Borgess Medical Center, Kalamazoo, MI,
September 21, 1989 (South Central Michigan);

St. Mary's Health Services, Grand Rapids, MI,
October 19, 1989 (South Central Michigan);

Grace Hospital, Detroit, MI,
November 29, 1989 (Detroit area).

Summary of Important Recommendations Regarding Timing and Site Selection:

The experience of the project lead to the conclusion that the timing and location plays a very important role in the success of training of physicians. The success of a training project can be doomed at the start if incorrect decisions are made in these areas. It is important to analyze the local community and the special characteristics of the medical profession in the community in selecting locations and dates for training. The office of the State Medical Society, or the local medical society can provide useful assistance in this regard. Other agencies (such as medical schools) which provide continuing education for physicians can also

be helpful. Some issues we found to be important are summarized here.

Day of the Week: It is important to consider which day of the week is the "traditional" day for medical in-service training in a community. This can vary greatly from one part of the State to another. If a day is selected which is not commonly used for medical education, it will conflict with prior plans for too many physicians, and attendance will be low. An appropriate day will take into account the day of the week most physicians in the area take off, when rounds are made, etc.

Communities that Work Together: Certain communities are used to working together, while others traditionally do things independently. A training program may plan to locate in one of two adjacent cities, assuming they are near enough for easy commuting. If, however, professionals in these two locations are not used to working together, the conference will not be likely to attract physicians from the other city. Conversely, professionals from two other cities may consistently attend activities in either location. It is not wise to try to abrogate existing community professional patterns.

Reputation of the Training Site: Finally it is important to select sites which are well accepted as locations for continuing medical education. One should not, for example, select a hospital which has low prestige in the community or which does not share the dominant community values.

PUBLICITY AND PUBLIC RELATIONS:

Publicity and Public Relations is a complex area involving the manner in which the elder abuse conferences were to be presented to the public, including the physicians who were the target population for training, the communities in which the training was to occur, the institutions which were the locations for the conferences, as well as other professionals who might have an interest in the training.

At the suggestion of members of the Advisory Committee, the project staff assumed a multi-faceted approach to publicity for the training. While the major portion of the publicity was directed toward physicians themselves, some advertising also focused on elderly citizens in Michigan, asking that they make their own personal physicians aware of the problem of elder abuse and the availability of training for physicians.

One of the first tasks to be dealt with in publicizing the training program was a title for use in publicity. The official project title ("Statewide Short-Term Training and Continuing Education for Physicians on Elder Abuse") was too long and unwieldy for use in press releases and brochures. We also wished to eliminate the term, "training," since it might imply that non-physicians were attempting to provide training to physicians. To stress the fact that the training was sponsored by physicians for physicians, the title, "Michigan Physicians' Conference on Elder Abuse," was selected for use in describing the project to physicians and the public.

Approaches to Physicians:

Our publicity plans with reference to physicians were twofold. First, general announcements were made to the medical profession as a whole beginning immediately, so as to alert physicians to the new adult abuse mandatory reporting law for physicians and make them aware of the upcoming conferences. Members of our Advisory Committee and staff members at the Michigan State Medical Society advised us that we should do a general mailing to all members of the Michigan State Medical Society; the project budget did not allow for such a mailing however. In its place, we arranged to have an article published in the official journal of the Michigan State Medical Society, discussing the problem of elder abuse, neglect, and maltreatment; describing Michigan's new mandatory reporting law as it applies to physicians; listing the dates and locations of training; and encouraging physicians to attend.

Second, more specific information was targeted toward physicians in the key subspecialties and in the geographic areas surrounding each specific site. A brochure was developed for distribution, both to physicians and to others. (A copy of the brochure and flyer may be found in Appendix B.) Announcements were timed to be sent out approximately one month prior to the specific date of the conference in that area. Mr. Tom Plasman, staff member with the Michigan State Medical Society, provided us with access to lists of Medical Society members, and gave advice on techniques for reaching the members. Information about the training was also

sent to each area hospital, with the request that they be placed in the mailboxes of each physician, as well as on the medical staff bulletin boards of the hospitals.

As indicated in our proposal, four major groups of physicians were targeted: Internal Medicine and Family Physicians, since they treat large numbers of older adults; and Orthopedic and Emergency Medicine specialists, since they are most likely to treat trauma patients. We attempted to reach these groups will be reached through the newsletters of the specialty groups to which they belonged. Most of these contacts were handled for us by the staff of the Michigan State Medical Society, particularly Mr. Plasman.

Approaches to the Aging Population of Michigan:

In addition to publicizing the conference to physicians directly, it was decided that we should make the project known to senior citizens, in the hope that they would make their personal physicians aware of the problem of elder abuse and the availability of training. A major way in which Michigan Senior Citizens make their voice heard in the Michigan legislature is the annual "Senior Power Day," on which Seniors from all over the State converge on the State Capitol, Lansing. This occurs in mid-May. Arrangements were made for the physician training project to have a booth at the convention center on that day, distribute brochures, have an ad in the program, and make a short announcement about the training. All were geared toward interesting Seniors in our project and asking them to inform their physicians about elder abuse training.

The State Office on Services to the Aging, a co-sponsor of the project, also allowed the use of their avenues to contact seniors. The training was announced in the newsletter they publish. In addition, the Office of Services to the Aging sponsors a radio program, entitled "Successful Aging." On this program, which is syndicated to radio stations throughout the State of Michigan, one of the co-Principal Investigators was interviewed by program moderators, Lara Trim and Ernie Condell, at Star City Production Studios in East Lansing, Michigan. The program discussed the problem of elder abuse and described the conferences, their objectives and locations.

Additional opportunities for publicity arose with the commencement of the conferences. In conjunction with our first Conference in East Lansing, the project had both newspaper and television coverage. On the day before the Conference, the Lansing State Journal published an article on elder abuse and the Conference. Rosella Fuller, who appeared in one of our videotapes, was highlighted in the article. In addition, a television crew from Station WLNS, Channel 6, in Lansing attended the first Conference, showing a segment of the Conference on the evening news that night.

While it is difficult to evaluate the effectiveness of these media efforts, our impression is that contacts with senior citizens and the mass media were of little value in reaching physicians. These impressions were somewhat confirmed by the results of our evaluation questionnaires, which indicated that few attendees had

learned of the conference from the mass media or from non-medical sources. (These data will be discussed in detail in a later chapter.) Since these articles and media appearances discussed the general problem of elder abuse and some of the sources of assistance for these cases, they were, no doubt, of value in making senior citizens and the general public aware of elder abuse as a problem. As public education they were a useful expenditure of time and resources. As a means of accessing physicians, however, they were not useful.

Approaches to Other Health and Social Service Professionals:

The conferences had originally been planned exclusively for physicians, with other professionals being invited only if they were accompanying a physician as a member of his/her medical team. This was done because of prior experience which had indicated that physicians rarely attend conferences which are planned to include persons in other health related fields (O'Brien, 1988a). It was also hoped that other professionals would encourage their physician colleagues to attend. Consequently, publicity directed toward other health and social service professionals was also developed. These efforts were escalated after the first two conferences, when it became obvious that there would be more than sufficient room for other professionals to attend.

Included in the outreach to other health and social service professionals were presentations by both Principal Investigators to classes at the universities involved in the project. Dr.

Sengstock also made presentations to the Wayne County Adult Protective Services Network, of which she is co-chair. This group consists of health and Social service professionals in the Detroit area who are experienced in working with victims of elder abuse and neglect and who know, from first hand experience, the importance of training in this area. It was hoped that the professionals and students reached through these presentations would attend the conference as well as make its availability known to their physician associates.

Other Public Relations Issues:

These include contacting personnel at each of the sites at which conferences are being held in order to assure that physicians and other health professionals in each area were aware of the conference, and that local facilities fulfill the needs of the participants. This involved contacting local personnel to arrange for audiovisual equipment, lecterns, lunch facilities, etc. These contacts also provided other means for publicizing the conferences through local media and personnel.

Our most successful publicity efforts, by far, occurred as a result of these contacts. The Kalamazoo Conference was to take place at Borgess Medical Center. The staff of the Geriatric Assessment Center associated with this hospital provided the project with considerable assistance in the area of publicity and public relations. Douglas Hall, Director of the Center, provided the project with valuable contacts in the community. His two

assistants, Kathy Huss and Marlene Denenfeld, personally assumed the task of distributing several hundred letters to physicians and other health professionals in the Kalamazoo area. This local support proved to be our most valuable resource in the area of public relations.

Problems of Publicity and Public Relations:

Numerous frustrations occurred in the area of publicity and public relations. The printing of Conference brochures and flyers was considerably delayed by administrative obstacles at Wayne State University, making them unavailable for Senior Power Day, as well as delaying publicity for the June Conference in East Lansing.

The lack of sufficient funds in the project budget to arrange for a general mailing to all physicians in the State was an additional problem. While our original budget had included this item, it is difficult to determine, in retrospect, whether such a general mailing, which would be extremely expensive, would have had an impact greater than publicity in the Medical Society publications.

Another problem of public relations occurred with reference to the need to charge for the training. In our original agreement with the Administration on Aging, the funding agency had made clear to us the position of the Administration on professional training. This consisted of the assumption that professionals have a responsibility to pay a fee for their own professional training; it should not be provided without cost by governmental agencies.

While this may be a laudable goal, charging fees for training proved to be a problem in several respects. Several hospitals we sought as training sites informed us that they had a policy of not charging their own staff physicians for training provided on site. This created a problem with some physicians in an area paying a fee, while others did not.

It also appears that requirement of a training fee is based on an assumption which is applicable only in certain instances. Where the training provided is under some criterion of licensure, or is in an area which the professional him/herself views as a desirable goal, it may be appropriate to charge a fee.

Training about elder abuse identification and services, on the other hand, is an area which the vast majority of physicians do not consider an issue which is necessary or desirable for them to understand. Licensure requirements for physicians require only a specified number of hours, which can be taken in a wide variety of areas. We were frequently informed that most physicians prefer to attend sessions which focus on new procedures which are of specific medical interest or may provide possibilities for increasing their office income.

Working with abused elders, in contrast, is likely to cost them time, money, and effort, in addition to the possibility of being sued. Most would rather not think about it. With this type of training, it is counterproductive to charge a fee. Instead, it should be made as enticing as possible, much in the manner that drug companies lure physicians to conferences about their new

products, not only with free registration but with lavish meals and accommodations.

The original plan to focus solely on physicians created numerous problems for public relations. We chose to take this approach because previous experience with other elder abuse conferences (O'Brien, 1988) had shown that physicians generally did not attend conferences when other professionals were included.

However, the request of allied health professionals (i.e., non physicians) to be included in the training arose several times in the early months of the project. This request initially came from several of the hospitals which were serving as hosts of the conference. Many hospital administrators felt that allied health professionals played important roles in working with abused elders and provided important sources of assistance to physicians as members of the health care team. Both they and the physicians recognize the value of having these allied health professionals obtain such training as well.

On the other hand, there was a concern that the training might cease to be focused on physicians if allied health professionals were included. Physicians might conclude that it was not directed toward them, or might believe they could send their nurses or aides, instead of attending themselves.

To encourage a team approach to care of abused elders and accommodate allied health professionals who wished to attend, we initially decided to allow such persons to attend only if they were accompanying a physician with whom they work. This, we hoped,

would emphasize the fact that the training was primarily for physicians, but still would allow the physician to bring his/her trusted allied health associates if desired. It was also hoped that interested allied health professionals would urge their physician colleagues to attend so that they might accompany them.

As time progress, however, and we became aware of the poor attendance at the initial conferences, we again revised the project strategy with regard to auxiliary medical personnel not accompanying a physician. Any vacancies remaining during the final two weeks of registration for a specific Conference were opened to non-physicians who wish to attend. We decided it was preferable to provide allied health professionals with the clinical techniques of identifying abused elders, in the hope that this information could then be transferred by them to their physician colleagues.

The lack of attendance at the conferences was a continuing problem. While we were aware from the beginning that it would be difficult to interest physicians in training on this topic, we had anticipated somewhat greater response than was received. In retrospect, it appears that the most effective method for generating physician interest in such a conference is the presence, on the local level, of an informed, industrious, and committed group, who will take responsibility for local sponsorship of the conference. The single most successful conference in our series occurred in Kalamazoo, Michigan, where such a local organization assumed this responsibility. To the other areas, we were outsiders whose knowledge of their local needs was probably suspect.

Since the one day physician training conferences, in the format established here, have not proven to be a very effective method of reaching physicians, the conference staff has been searching for other techniques of reaching physicians which might be more effective. These included modifications of the training to fit into shorter time periods, such that they might be presented to hospital staff and residents during a series of lunch hour seminars or at meetings of professionals societies. In this manner, segments of the Michigan Physicians' Conference on Elder Abuse have been presented by each of the Principal Investigators at the November, 1989, meeting of the Michigan State Medical Society, at lunch hour seminars at St. Lawrence Hospital in Lansing, and at a conference of the Detroit Medical Society.

Conclusions Related to Public Relations:

Our experience with the Michigan Physicians' Conference on Elder Abuse has lead us to be extremely conscious of the importance of the manner in which professional in-service training is presented to the professional population. A number of suggestions could be made.

Importance of Insider Education: Every effort should be made to indicate that the in-service training is provided by the profession for the profession. It should not appear that outsiders are attempting to train members of a profession other than their own. In the Michigan Physicians' Conference on Elder Abuse, this was accomplished by the name used for the training program, by the co-

sponsorship of the Michigan State Medical Society, by including members of the profession as trainers, as well as by including topics specific to that profession in the training materials.

A Multi-Faceted Approach to Public Relations: A number of different approaches to reach the target population are necessary, since no one approach is likely to reach any single individual. COntacts through a hospital staff may reach some physicians, for example, while another will be attracted by information read in the professional journal.

The Use of Mass Media or General Population Approaches to Professionals: Our experience suggests that techniques of reaching physicians through indirect methods bore little fruit. While we had not expected the mass media efforts to reach physicians directly, we had hoped that contacts with senior citizens and professionals in other fields could be used to inform physicians about elder abuse and the availability of training. In retrospect, this was probably quite naive. Only direct efforts, preferably through the physicians' own professional contacts, are likely to be useful. Hospital staff contacts and the State Medical Society are examples.

The Problem of Charging for In-Service Training: As indicated previously, charging professionals for in-service training may be appropriate when the training is in an area which is required for licensure, or is on a topic which professionals themselves recognize as necessary or desirable. When members of the profession do not yet recognize the value of the training however,

and outside agencies are attempting to generate concern in the profession for a new area, fees should not be charged. On the contrary, special inducements should be made to entice the professionals to attend.

Inclusion of Allied Health Professionals: Our original plans to exclude allied health professionals, while well intentioned, proved to be divisive and ineffective. Many physicians depend upon their allied health personnel specifically to deal with issues, such as cases of abuse and neglect, from which they would like to distance themselves. Simultaneously, allied health professionals pride themselves on their skills in handling these cases. Excluding them from the training, or allowing them to attend only on a limited basis, did more harm than good.

The Critical Importance of Local Sponsorship: Finally, the single most important factor in scheduling a successful conference was the existence of strong support for the training at the local level. This does not solely include the selection of a site which is easily accessible and enjoys strong respect in the community. Rather it involves the necessity of locating a group or institution which will take responsibility for sponsoring the conference on the local level, and will use its institutional reputation in the local community to promote the conference.

PART IV

DEVELOPMENT OF TRAINING MATERIALS

The major task of the project on "Short-Term Training and Continuing Education for Physicians on Elder Abuse" was the development of training materials appropriate for presenting the problem of elder abuse and neglect to physicians. Three major dimensions of training were considered in the process of developing the training programs. These were: the overall content to be included in the training; the form which the training materials should assume; and the manner in which the content should be developed in reference to the form of the materials.

Content of the Training:

A tentative outline of training content was developed early in the project term. Four major content areas were delineated as follows:

General Introduction to the Problem of Elder Abuse: The first area to be covered is a general introduction to the problem of elder abuse and neglect. This topic includes such issues as the definition and types of elder abuse; the frequency or magnitude of the problem; suggested causes of abuse and neglect; and other problems which may be correlated with abuse. Specific emphasis will also be placed on the physician's unique role in identifying and managing cases of abuse and neglect of the elderly.

Legal Dimensions: An introduction to the legal issues in the consideration of elder abuse was considered essential. Among the critical topics to be included are an explanation of Michigan's mandatory reporting law for abuse and neglect of the elderly, with specific consideration of the manner in which it applies to physicians. The legal protections which exist for those who report abuse is another topic of concern to physicians. Finally, some related legal issues, such as guardianship and conservatorship, will be considered, along with the manner in which they may be either a source or a resolution of the problem of abuse of the elderly.

Clinical Symptoms of Abuse: The most important component of the training focuses on those aspects of elder abuse and neglect which are uniquely medical in character. These consist of the clinical manifestations of abuse and neglect. In this area are techniques for detecting abuse and/or neglect in clinical settings; methods of distinguishing symptoms of abuse or neglect from the characteristics of normal aging; and important clinical tests which may help to formulate these distinctions.

Referral and Case Management: Finally, it is critical to provide physicians with information on the manner in which cases of elder abuse and neglect which are observed may be managed in the medical setting. This topic includes consideration of the community services which are available in cases of abuse and neglect; where

to refer abused patients; the types of problems faced by families in caring for a dependent elder and how to obtain assistance for them in providing care; and what to expect from the State Department of Social Services in cases that are referred to Adult Protective Services.

Having delineated the major areas to be covered in the training, we proceeded to determine the appropriate methods for presenting the materials.

Form of Presentation in the Physicians' Conferences:

We considered several modes in which to present the materials in the Conferences. These include lectures, group discussion, question and answer sessions, as well as various types of visual materials, such as slides, overhead transparencies, and videotapes. The advantages and disadvantages for each of these were considered in determining which mode to use for various purposes.

Lecture Format: The lecture format is obviously the most widely used format, and is a useful means of presenting a large body of information in the shortest amount of time. Since we have a large quantity of information to present, it was recognized that we would very likely have to make use of the lecture format for a considerable amount of it. On the other hand, the lecture format can be tedious and boring if it continues for too long a time. Consequently we planned to vary the format wherever possible, both by using other modes of presentation for some materials, and by

inserting various visual materials within the lecture format at other times.

We also recognized that it was important to make use of the lecture format only in those instances in which it was appropriate, i.e., to present a body of factual material. Care should be taken not to use this approach where another format, such as a videotape or group discussion, would be advisable.

Group Discussion: The group discussion format is most appropriate when the issues to under consideration do not constitute a body of factual data. Topics which are susceptible to a variety of interpretations are appropriate topics for group discussion. Examples of topics in this category would be suggested referrals for a patient with a specific set of symptoms and characteristics, possible causes for a cluster of symptoms, or the needs of a family manifesting multiple problems. It was also recognized, however, that it is not always easy to generate discussion in a group. Consequently, we were anxious to develop techniques which would be likely to generate discussion within the Conferences.

Question and Answer Sessions: Midway between lecture and group discussion, in terms of its degree of structure, are question and answer sessions. We believed that such sessions would be most effective when the audience had been presented with a body of complex information which might be somewhat unclear, or which would lead members of the audience to think of additional topics which

might be problematic.

Slides and Overhead Transparencies: We considered the possibility of using both slides and overhead transparencies to enliven the lecture materials. Both formats can be used to highlight textual material being presented. Overhead transparencies, however, are difficult to use with photographic material. Consequently, where we wished to use photographs, they would have to be in slide format. The use of both slides and overhead transparencies in the same presentation presents some mechanical difficulties, requiring the presenter to switch from one format to the other. Consequently, slides were selected as the format for use with both photographic and textual materials.

Videotapes: Considerable discussion was allocated to the use of videotapes, particularly with reference to the relative value of videotapes versus slides. Slides are a static representation of an image, while videotapes present a dynamic perspective. Consequently, it was important for us to differentiate between static and dynamic materials in selecting the topics for our slides and videotapes.

The identification of clinical symptoms of abuse and neglect had originally been considered as a possible topic for a videotape. Upon reflection, however, it was recognized that clinical symptoms essentially constitute a static issue. That is, they are best presented by depicting an abuse symptom in contrast with a symptom

of non-abuse. Hence this is not an appropriate topic for a dynamic form such as a videotape.

Videotapes, on the other hand, would be adapted to the demonstration of social processes. For example, a videotape might be used to demonstrate the process of interviewing a patient or family member, of obtaining a case history, or of conducting a physical exam of a patient. Hence videotapes would be reserved for such process oriented materials. Examples included the process of obtaining information on abuse by interviewing a victim or of informing a family member that abuse was suspected. This latter example also illustrates another use of the videotape form, namely, as a technique for generating discussion or raising questions.

Use of Supplemental Trainers:

Another issue to be considered in developing the format of the presentations revolves around the nature of the presenters. It was understood that the Co-Principal Investigators, as originators of the project and authorities on the subject of elder abuse, would handle two of the presentations. Some of the topics, however, were outside of our areas of expertise.

Three major areas were delineated for which supplemental trainers would be required. In the legal area, it was preferable that the issues be raised by an attorney with knowledge both of legal issues in general and also of issues related to the mandatory reporting of abuse in Michigan. In terms of case management and referrals, the input of allied health and social service personnel

with knowledge of possible referral sources would be advisable. Finally, the input of the official agency responsible for receiving reports of abuse and neglect was deemed necessary. Consequently, Adult Protective Services workers from the State Department of Social Services were invited to provide information at each session on procedures of Adult Protective Services in Michigan.

Development of the Materials:

Once the format and content of the training had been resolved, the major project remained to develop the lectures, slides, and videotapes to be used in the Conferences. In the remainder of this section, we will describe the manner in which these materials were developed, the difficulties which were encountered, and the manner in which they were resolved.

Lecture Materials:

Development of the lecture materials was actually a twofold responsibility. It involved not only the development of the outline of the lecture itself, but also the development of the overall outline of the presentation, including audio-visual materials. It was determined that Dr. Sengstock would take primary responsibility for development and presentation of the initial lecture, providing a general introduction to the problem of elder abuse. Dr. O'Brien took responsibility for preparing and presenting the material on the clinical identification of elder abuse.

Primary responsibility for the other two presentations were assigned to supplementary training personnel. Mr. Thomas Trainer, Attorney specializing in legal problems of the aged and a member of the Advisory Committee, was responsible for developing and presenting the lecture on legal issues. The presentation on the referrals and case management was developed by Ms. Sue Haviland, Nurse Practitioner, and Mr. Leon Schrauben, Gerontological Social Worker. This lecture was also determined to be the appropriate place for the presentation by a representative from the local office of the Adult Protective Services unit of the Michigan Department of Social Services.

In addition, the Co-Principal Investigators were involved in the development of the outlines for all of these presentations, and were responsible for insuring that the content of each presentation was appropriate and complete, and that the materials for the various presentations were not repetitious of each other.

The first presentation of the materials occurred at the initial Conference, held at the Michigan State University CLinical Center in June, 1989. This Conference provided the project staff with an opportunity to review the materials and consider the possibility of changes. This process resulted in a number of revisions, both to the lecture content and to the audio-visual components.

Two major alterations in the lectures occurred. Overall, it became obvious that there was some duplication of material among speakers at the Conference. For example, both Dr. O'Brien and Dr.

Sengstock had included general information and identification material in their presentations. The case management presentation also repeated some of the materials from the introductory lecture. All three presentations were revised to avoid this duplication prior to the second Conference in Marquette, Michigan, in August. Slides appropriate to the revised lectures were also developed.

The greatest number of changes occurred in the case management presentation. As noted above, the material which duplicated the introductory lecture was removed, allowing extra time. The videotape for this section was also revised, a topic which we will discuss shortly. Both of these changes required that the lecture material be revised. These revisions involved the inclusion of more detailed information on referral sources for use of physicians in dealing with abuse and neglect victims. This information had originally been included on the videotape; we found, however, that this material could be provided more effectively in lecture form. Additional information was also added on case management and the delegation of responsibilities among members of the health care team.

Audio-Visual Materials - Slides:

Considerable time was been spent in locating slides, film strips, etc., which might be used in the training. One particularly helpful source was the Elder Abuse Interdisciplinary Team at St. Vincent's Hospital in Toledo, Ohio. Also helpful was Ms. Terri Boyd, Enterostomal Nurse at St. Lawrence Hospital. Both

provided useful suggestions on slides which might be useful.

One problem encountered in the search for appropriate slides was the fact that existing materials were not easily adaptable to a physician audience. We found that most visual presentations on elder abuse were better adapted to "shock" lay audience than to instruct physicians. Consequently, it was necessary for the Michigan Physicians' Conference on Elder Abuse to develop new slides.

Three presentations were planned to include slide presentations as part of the materials. These were "Introduction to Elder Abuse," with Dr. Sengstock; "Clinical Identification," with Dr. O'Brien; and "Referrals and Case Management," with supplementary trainers, Ms. Sue Haviland and Mr. Leon Schrauben.

As indicated earlier, two types of slides were prepared. Text slides are training aides, which enable the presenter to flash important text material on the screen for emphasis. Illustrative slides are photographs, drawings, and other pictorial material which serve to illustrate the points the lecturer wishes to make. Illustrative slides are particularly useful in the "Clinical Identification" lecture, where it is important to illustrate the difference between various symptoms of abuse, neglect, or exploitation, and the more benign symptoms of the normal aging process. Resources of the audio-visual department of the Michigan State University College of Human Medicine were extremely helpful to us in the preparation and production of slides.

Audio-Visual Materials - Videotapes:

The materials presented in videotape form are essentially different from those to be presented in the slides, as described above. Slides are effective for the presentation of relatively "static" material, such as illustrating the difference between abuse symptoms and benign ones. Videotapes are dynamic, and are, therefore, useful for the illustration of process, such as the process of interviewing an elderly patient or consulting with family members. They can also be useful in raising questions which are common but which many people may be reluctant to raise; this may serve to generate discussion on the part of an audience.

Three of the presentations ("Clinical Identification," "Legal Issues," and "Referrals and Case Management") will have videotapes as part of the materials. Consequently three videotapes were developed, as follows:

"Clinical Identification" Video: This video, to be used in Dr. O'Brien's presentation, will illustrate three processes: the first, in which a physician consults with other medical personnel and learns that an elderly patient may be at risk of abuse; the second, illustrating appropriate techniques for the physician to interview the patient, alone, to obtain critical information; and the third, illustrating the manner in which physician and other medical personnel bring together their unique points of view to assess the patient's situation and draw some conclusions.

Dr. James Kursch assisted us by playing the role of the

physician in this film, with Ms. Kay Thiede as the nurse. Both have worked closely with elderly patients and played their roles in excellent fashion. An elderly volunteer, Ms. Rosella Fuller, was exceptionally effective playing the role of the patient.

"Legal Issues" Video: The second video was designed for Mr. Trainer's presentation on the Michigan mandatory reporting law, its consequences for victims as well as physicians, and other legal issues. This video is designed primarily to raise some of the major questions and concerns which physicians may have about the reporting of elder abuse, to suggest some answers, and to generate discussion on the issues.

For this video, Dr. O'Brien and Dr. James Craig, a resident in the Department of Family Practice, raised some of the legal questions, with Mr. Thomas Trainer, consultant on legal issues, responding. We are quite satisfied that this video will assist physicians in understanding the legal dimensions of the problem of elder abuse.

"Referrals and Case Management" Video: This video was planned on the same model as the "Clinical Identification" Video, with three segments: professionals discussing a case, a conference with the family, and a final concluding conference by the professionals evaluating the case outcome. Dr. Rod Walker, a resident in the MSU Department of Family Practice, Nurse Sue Haviland, and Social Worker Leon Schrauben played the roles of the professionals in this

video. Chuck and Harriet Renie, volunteers in the out-patient department at St. Lawrence Hospital, played the roles of the patient/caretaker couple.

The outcome of this video was entirely unsatisfactory. We had planned for the video to illustrate the process by which physicians confront the patient and his/her family with the issue of abuse, neglect, or exploitation; demonstrate possible reactions they may exhibit; and suggest ways in which medical personnel may handle these reactions. However, too much time was given to a discussion of the case by the professionals, raising issues which could more effectively be presented in lecture form. As a result, the major goal of this videotape was not accomplished.

A revised videotape was developed which focused more clearly on the process of discussing problems of abuse and neglect with victim and/or family. Two versions of this videotape were developed, one providing a negative example, the other a more appropriate approach. Mr. Andrew M. Goldynia, our Research Assistant, played the part of the alleged abuser, with Dr. James Craig, resident in Family Practice, repeating his "Clinical Identification" role as the physician.

This revised version was more successful for a number of reasons. First, there was a more limited goal; rather than attempting to combine discussion of referral sources with demonstration of the interview process, we focused specifically on the approach to the family and/or abuser. Second, the revised version followed our original plan to use videotaped materials

specifically to demonstrate process, and to leave textual materials for the lecture format. Third, the two versions allowed the opportunity for us to use this video as a means of generating discussion with the audience, another advantage of the video approach. Finally, with these more focused goals, the actors were better able to perform their roles.

In addition to these scripted videotapes, we had the opportunity to tape the entire Conference at the Traverse City location. These videotapes, copies of which are being supplied to the Administration on Aging, provide a complete record of the entire Conference, including lectures, slides, videotapes, group discussion, and question-and-answer sessions. Only one change was made to these videotapes, as they were recorded at the Traverse City Conference. The presentation from the State Department of Social Services Adult Protective Services had not been of the same quality as the APS presentation in the other locations. Consequently, Ms. Jan Baszler, who had made the East Lansing presentation, was asked to repeat her presentation on videotape at the Michigan State University studios. It is this version, inserted in the Traverse City videotape, which serves as the official record of the Conference.

Handouts for Conference Attendees:

The packet of handouts, a copy of which has been sent to the Administration on Aging with this report, was distributed to each attendee. This packet included an agenda of the Conference,

indicating the times for each presentation and names and credentials of the presenters. Copies of outlines for each presentation were also included, as was a bibliography of medical references. The Program Evaluation Form and a form to be submitted for CME (Continuing Medical Education) units were also included. These items were all color coded to allow participants to locate each set of materials easily. (See Appendix C for copies of these items.)

A great deal of background material was also enclosed in the packet. Sengstock-Hwalek Comprehensive Index of Elder Abuse (Sengstock & Hwalek, 1986a), and the accompanying Instruction Manual (1986b) was enclosed, as was the "EAST" ("Hwalek-Sengstock Elder Abuse Screening Test"; cf. Hwalek and Sengstock, 1985a, 1986). A pamphlet from the Area Agencies on Aging, describing possible referral sources, was added. Several booklets from the Michigan Department of Social Services describing the Adult Protective Services law and procedures, including a special pamphlet describing the obligation of physicians, completed the packet. (See Appendix F for a complete list of these items.)

Summaries of the Four Presentations:

As indicated above, outlines of the final form of each presentation were included in the information packets distributed to each attendee. At this point, we will provide a short description of each presentation, including visual materials. The objectives of the Conference as a whole were: 1) to provide a

general introduction to the nature and types of elder abuse; 2) to acquaint physicians with some of the major factors which may be associated with elder abuse; 3) to suggest some approaches to assisting elderly abuse victims, through identification, referral, and assistance to both family victim. The first presentation was to focus on the first two objectives; the other presentations would elaborate on the third objective.

"Introduction to Elder Abuse":

(Developed by Mary C. Sengstock, Ph.D., C.C.S., Professor of Sociology, Wayne State University)

The introductory presentation opened with a discussion of the objectives of the Conferences as a whole and a short history of the consideration of elder abuse as a public health issue. While the problem has probably existed for a long time, it has only become an issue of public concern since approximately 1978. It gained interest with the publication of several early studies on elder abuse in the early 1980s (Block and Sinnott, 1979; Hickey and Douglas, 1981a,b; Sengstock and Liang, 1982, 1983; Lau and Kosberg, 1979).

Concern with the problem gained momentum with the report of the House Select Committee on Aging (Pepper and Oaker, 1981), on which Rep. Claude Pepper of Florida and Rep. Mary Rose Oakar of Ohio were key members. Interest in elder abuse has grown with the foundation of the National Aging Resource Center on Elder Abuse (NARCEA), founded by the Administration on Aging in 1988, the first

population survey on elder abuse (Pillemer and Finkelhor, 1988), and the establishment of elder abuse laws in most states.

Rates of abuse have varied with the study. In an early study, Block and Sinnott (1979) reported a rate of abuse by the family of 6.7/1,000. In Michigan, there have been about 5,600 to 6,000 cases reported to Adult Protective Services in each of the last three years for which data was available; approximately 56% of these were persons 60 and over, with about 25% 70 and over. These cases, of course, represent only those cases which are reported. Pillemer and Finkelhor (1988), in the first population survey on abuse, found a rate of 32/1,000.

The presentation continued with a discussion of the definition and types of elder abuse. Six types were delineated and defined: Psychological Neglect (social isolation); Psychological Abuse (verbal assaults); Violation of Personal Rights (forcing or prohibiting behavior to which adults should be entitled); Material Abuse (theft or misuse of property); Physical Neglect (failure to provide the physical necessities of life); and Physical Abuse (direct physical assaults, including sexual assault). Examples, with illustrative slides, were provided to elucidate each type of abuse.

The presentation then focused on some interrelations between the types of abuse. Rarely does a case involve only one type; several types often occur together. There is often a progression from the less serious types mentioned first (psychological neglect and abuse) to the life threatening types mentioned later (physical

neglect and abuse). Hence observation of the less serious types may serve as a warning and intervention may prevent the occurrence of more serious types later.

Another issue that arises in considering the various types of abuse arises from the fact that the frailties of the elderly often place them and their families in contradictory situations. Ont the one hand, elders often wish to maintain their independent life style as long as possible; on the other hand, they may be too infirm to handle the situations which may arise. For example, mother may insist that she wants to remain in her three story home; her children worry that she is unsteady on her feet and may fall down the stairs. Consequently, their family members are frequently faced with a dilemma: Shall they insist that she move, and be accused of violating her right to live where she chooses? Or shall they violate her right to live where she wishes, and risk being accused of neglect should she fall? In either case, they are, in a sense, responsible for abusing or neglecting their aged mother.

The presentation then moved to a consideration of the physician's unique role in dealing with elder abuse. Physicians are in a better position to identify and refer cases of elder abuse for four reasons: more elderly see physicians than any other professional; the elderly trust physicians more than any other professional; only physicians have access to critical tests, such as laboratory tests; and physicians are in a position in which they must serve as a resource to other professionals.

Physicians in particular should be concerned about the problem of elder abuse, since the existence of the problem may circumvent the effectiveness of carefully developed care plans. Elders may experience trauma from which their aging bodies cannot recover; they may be unable to obtain prescribed food or medication because of neglect or financial abuse; they may experience depression over abuse or neglect, resulting in a situation similar to "failure to thrive" in infants.

On the other hand, physicians have generally not been concerned with elder abuse, as indicated in Dr. O'Brien's survey data (O'Brien, 1988a). Although the physicians studied all came from state with laws involving elder abuse, over 80% were unaware of these laws. Eighteen percent of the respondents reported seeing at least one case of abuse, and another 20% had seen a case which they suspected to have been abuse, the most frequent type being neglect. Yet 96 percent had no procedures for detecting abuse, which 87 percent believed to be difficult to detect.

A number of factors which may be related to abuse or neglect of the elderly were presented. Attendees were reminded, however, that most studies of elder abuse and neglect are based on an analysis of small samples of cases already known to agencies. Consequently, the results should all be viewed with caution.

Demographic characteristics of victims were considered. Most victims are females, since most elderly are female. However, a recent study suggests that men may suffer a higher rate of abuse (Pillemer and Finkelhor, 1988). While abuse can occur with fully

competent elders, the incapacitated probably experience a higher likelihood of abuse (Wolf, et al., 1984). Elder abuse and neglect can occur in all racial, religious, ethnic, and economic groups (Sengstock and Liang, 1982, 1983).

The alleged abuser can be either male or female. While it is generally assumed that the abuser is the offspring of the victim, the data indicate that a wide variety of persons can be responsible of abuse. Other offenders may be siblings, grandchildren, other relatives, landlords, roomers, or neighbors (Sengstock and Liang, 1982, 1983). The offender may be financially dependent on the victim (Wolf, et al., 1984). Some of the abuse is spouse abuse; in some instances, the abuse may have continued for years. In other cases, the victim may be reversing an earlier pattern, with a battered wife now taking her revenge.

While we have no way of knowing whether the current cases represent an increase from former years, demographic changes in today's society do much to promote abuse of the elderly. There are an increased number of elderly for which the family must provide care; at the same time, families are smaller, with fewer children to provide the care. Families are dispersed geographically, such that children are less likely to live near elderly parents when they need assistance. Women are less likely to remain at home; it is an economic hardship for them to provide care. In hospital treatment is more limited since the introduction of the DRG (Diagnosis Related Groups) system of health care payment; as a result, patients are often discharged in a more frail state,

requiring greater home care. Finally, the cost of medical care is often prohibitive, especially home care and nursing home placement, which are unlikely to be covered by insurance.

Care of the elderly is also more difficult than care of children. With children, there is increased independence each year; families can see an end to their care-giving days. With the elderly, care-giving responsibilities only intensify with each passing month or year. At the same time, caregivers are also experiencing problems. Many are themselves facing menopause, their own retirement, or caregiver burnout. Caregivers themselves are elderly in many instances. Hence the provision of resources and assistance to the caregiver is an important part of the solution to elder abuse and neglect.

The stress of caregiving on family relationships is an area of severe difficulty. Caregiving disturbs longstanding family power and status patterns, as the dominant husband now becomes dependent on his formerly submissive wife, or the wife who always cared for the home must now depend upon her husband to perform these chores. These problems are even more complicated when the living arrangements involve three generations, with the reversal of normal parent-child status structure, and the presence of grandchildren who may have different life styles. If the elder is bedridden, an additional problem occurs, since the need to provide personal and bathroom care violates the sexual taboos which are some of our society's most stringent prohibitions.

Finally, the problems of caregiving may be exacerbated by any

number of other factors in the family. The need to provide care for an aged parent may strain a parent-child relationship which may never have been strong. This family may have had previous incidents of violence. And the presence of substance abuse or mental illness may create additional strain.

This presentation closed with a discussion of the importance of identifying elders at risk of abuse and providing services needed by them and their families in order to stem the tide of abuse. These issues were scheduled for the remaining presentations of the day.

"Clinical Identification of Elder Abuse":

(Developed by James G. O'Brien, M.D., Director Programs on Aging, Colleges of Human and Osteopathic Medicine, Michigan State University)

The objective of this presentation were fourfold: 1) to provide a rationale for screening and identification of abuse; 2) to demonstrate how detection of abuse can be integrated into a primary care model of practice; 3) to review methods of identification of abuse including symptoms, signs and other indicators in practice settings; 4) to discuss some initial management strategies that can be utilized in addressing the problem.

Elder Abuse appears to meet the criteria which have been established for the screening for a particular disease, in light of the prevalence, morbidity, and mortality of abuse, and the

effects on the quality of life. As Frame and Carlson (1975) have indicated, these criteria include: 1) the prevalence of a disease/problem should be adequate to warrant screening; 2) known treatments should be available; 3) treatment during earlier stages should provide a better outcome that treatment during later stages; 4) acceptable methods of screening should be available; 5) the problem should cause significant morbidity and mortality; 6) the disease should have an asymptomatic period. On most, if not all, of these criteria, elder abuse qualifies as a problem for which screening should occur.

Elder abuse is a problem which benefits from general geriatric principles of care, as defined by Kennie (1983). These include: emphasis on maintaining and restoring function; broadened assessment; continuity of care; specific knowledge; maintenance of support system; cautious intervention; patient advocacy; community orientation; time for recovery; and the legitimacy of death. All but the last would appear to apply to elder abuse and neglect.

The presentation proceeded to the delineation of a profile of the elder at high risk of becoming a victim, as well as the caregiver at high risk of becoming an abuser. The high risk elder is dependent, isolated, or demented. S/he exhibits such behaviors as wandering, belligerence, not sleeping, depression, or pursuing the caregiver. Stress is present in the situation. The high risk victim experiences a sudden decline in function or failure to thrive. There is a pattern of delaying treatment, using numerous medical facilities, particularly emergency rooms, and failure to

comply with medical instructions.

The caregiver at high risk of becoming an abuser is a person with a prolonged history of providing care. S/he is typically providing care all alone, tends to refuse outside help, and is involved in a situation in which the care is a heavy burden. There may also be a history of violence, alcoholism, or substance abuse in the family.

Families in which any of these factors may be present are those in which there is a high risk of abuse or neglect of an elder. However, abuse can also occur in situations in which such factors are not present or may not be known. Consequently a screening for abuse is necessary. A two step approach, based on the Hwalek-Sengstock Elder Abuse Screening Test" ("EAST"), was suggested. (A copy of the "EAST" was provided in the packet, as described below.)

Step 1 focused on screening. In this section, patients would be asked whether they were frequently sad or lonely; if they had a critical support person to take them to the doctor; whether they had adequate finances or privacy; whether anyone in the family drank a lot or had problems with drugs; whether they needed help in managing their daily activities; and whether they were uncomfortable with anyone in the family.

Questions focusing more specifically on abuse and neglect fell into the category of case finding. These questions focused specifically on whether anyone had attempted to hurt or harm the elder; forced him/her to do things s/he did not want to do; had

taken things from the elder or made him/her stay in bed when they were not sick. Also included were questions regarding threats of being placed in a nursing home or statements that they were not wanted. A complete list of these questions was provided in the handouts.

Procedures for interviewing the victim were then presented, including the videotape illustrating proper interviewing techniques. It is critical that the interview be conducted in a quiet, private setting. The victim should be assured of confidentiality. Victim and caregiver/abuser should always be interviewed separately. The interviewer should establish rapport and be non-threatening, and should allow the victim time to express his/her feelings.

It is critical that the interviewer ask specific questions directly inquiring about abuse: Have you been struck? ... raped? Accurate documentation of information and symptoms observed should be kept. The interviewer should also determine the urgency of the situation: Is the elder in immediate danger?

Interviewing the caregiver/abuser should also be conducted in a non-judgmental manner. Stresses and the burden of caregiving should be determined. Any supports which the caregiver may have should also be determined. For both victim and caregiver, a good technique is asking the respondent to describe a typical day.

Directions were provided as to elements to be included in the physical exam. The patient should be screened for depression and mental status; suggested short forms for these purposes were

indicated. The patient's functional status should be determined; this can be done simply by observing the patient's ability to respond to his/her name, move about the examining room, remove his/her clothing. A list of questions for such an evaluation was included in the handout for this presentation.

Vital signs, including pulse, blood pressure, temperature, height, weight and weight history should, of course, be taken. The patient's appearance (hygiene, status of clothing, presence of wasting or emaciation) should be observed and recorded. Are prosthetics (walkers, dentures, glasses, hearing aids, etc.) available and in good repair?

The skin should be observed for abrasions, decubiti, dehydration, or rashes. The type, stage, and configuration of any bruises should be noted. Hair should be examined for evidence of hygiene, lice, or pulling. The mouth should be examined for evidence of dryness, vitamin deficiency, dental hygiene, and condition of the mucous membranes. The nose should be examined for evidence of fracture or deviation.

Bruising on any part of the neck, chest, breasts, underarm, or abdomen. Any indication of deformity, rib or soft tissue injury or tenderness should be observed. The extremities should be observed for range of motion, deformities, edema, or tenderness. A rectal exam should be conducted, looking for evidence of gaping, impaction, or proctitis. Since sexual abuse of the elderly is not unknown, the perineum should be examined for bruising, bleeding, or evidence of sexual assault.

Slides were presented to illustrate many of these symptoms. For example, slides depicting various patterns of bruises which may or may not suggest abuse were shown. Early stages of decubiti were depicted, to illustrate the need for early identification of skin deterioration. X-rays were shown illustrating fractures which usually are caused by direct blows. Slides were shown depicting injuries which remained hidden for many months, due to inaction on the part of medical personnel.

It is critical that a complete physical exam be conducted to look for hidden injuries. Evidence of abuse has sometimes been missed because the physician did not deem it necessary to conduct a complete physical. All observations should be clearly recorded, including diagrams and photographs, if appropriate. Supportive evidence might include laboratory tests, X-rays, or scans. The Sengstock-Hwalek Comprehensive Index of Elder Abuse (Sengstock and Hwalek, 1986a), which provides details of all of these symptoms, was provided as a part of the packet of handouts.

The physician should determine the degree of risk of immediate harm to the patient, should make a report of suspected abuse to the Department of Social Services, and consider possible referrals which might be appropriate, which will be the focus of the fourth session.

"Legal Issues in Treating Abused Elders":

(Developed by Thomas Trainer, J.D., Chair Senior Justice Committee, State Bar of Michigan)

Michigan and 37 other states have laws which were established to prevent or correct the abuse or neglect of people who are unable to protect themselves. In order to assist these people, some states have required certain professionals to report cases of suspected abuse or neglect to the attention of authorities. In a number of states, including Michigan, physicians are among those professionals so mandated. (See Michigan, 1982, 1987, for further discussion.)

Michigan's Adult Protective Services law covers four types of actions: "Abuse," which includes the infliction of physical or mental injury, including sexual abuse; "Neglect," which occurs when the person responsible for the individual's care does not provide adequate food, medical care, shelter, or clothing; "exploitation," in which an individual's property, money, or personal dignity are threatened; and "Endangerment," which indicates that the situation is life threatening. The term "abuse" is also used to apply to all of these categories.

The Michigan law protects individuals who are deemed to be "vulnerable," that is, persons who cannot protect themselves for various reasons. These may include the frailties of age or mental or physical deficiencies. The term "vulnerable" is different from the terms commonly used in the law to determine the appropriateness of guardianship or conservatorship; consequently, an adult may be termed "vulnerable" without indicating the need for other government intervention.

According to Michigan law, physicians, along with other

professionals, must report abuse if they "suspect" or have "reasonable cause to believe" that an individual is the victim of abuse. Under these standards, professionals are not required to be certain of the existence of abuse before making a report. If they merely suspect abuse, or if others viewing the same set of symptoms would be likely to believe so, then a report to Adult Protective Services would be required.

If abuse is not reported by a professional so mandated, civil fines and liability are the sanctions imposed. Licensure sanctions or liability for later damages may also be incurred. To date, no courts have handled cases under these laws. Such sanctions have occurred under Child Protective Services laws however.

Certain safeguards have been included in the law to protect reporters. Reports under these laws must be kept in confidence; hence the victim and abuser cannot be told of the identity of the reported. In addition, the reporter is guaranteed immunity from suit in the event of a report which turns out to have been unfounded. Again, the Adult Protective Services cases have not been tested, but cases under child abuse reporting laws support the issue of immunity.

Physicians were informed that the obligation to make a report is imposed upon the individual who observes it. This means that the physician personally has the obligation to report, even if other professionals, such as a nurse or social worker, have also seen the case and intend to make a report. The responsibility cannot be abrogated by institutional policy; that is, individual

reporters are not absolved of responsibility to report by a hospital policy requiring that all reports be channeled through the hospital administrator.

The lecture went on to discuss a number of other related legal issues, including the means by which to make a report, and some legal remedies which might be used to remedy abuse, neglect, or exploitation. Also included were issues such as guardianship, conservatorship, or powers of attorney, all of which may have importance in medical settings. A summary of all of these issues was included in the packet of materials distributed to Conference participants.

Finally, attendees were shown the videotape in which a physician, resident, and attorney are depicted discussing a case of abuse. As indicated previously, this videotape was designed to raise some of the major legal questions which physicians might have regarding the obligation to report abuse, questions such as: Do I really have to report? Can't I wait a few weeks to see if the situation improves? What if the report makes the family mad? Won't this incite them to sue me for something else later?

Not only did the videotape provide answers to some of these questions, it also generated additional questions from the audience. Some of the liveliest question and answer sessions were those which followed the legal presentation.

"Effective Management: Assessment and Resources":

(Developed by Sue Haviland, R.N., M.S.N., Clinical Nurse Specialist

in Gerontology; and Leon Schrauben, M.S.W., A.C.S.W., Medical Social Worker in Gerontology)

The final presentation focused on the management of cases of abuse or neglect in a medical setting. The session began with a general overview of the types of factors which should be considered in assessing cases of abuse and neglect. Having observed a case of suspected abuse, the professional can proceed to collect information which will validate the existence of abuse.

Even when abuse is not confirmed, the case should be monitored carefully, since this may be a situation of high risk of future abuse. The degree of involvement of the physicians will depend, to a degree upon the setting in which the abuse is observed. If the case is seen in an emergency room, with no prior contact with the patient, a report to APS may be the physician's only involvement; where the victim and/or family are long time patients of the physician, greater involvement in the case would be in order.

The family setting is an important context for the management of abuse cases. Families, victims, and caregivers have a number of strengths as well as dificiencies which must be considered. Among the strengths might be an ability to adapt to changes in the health status or roles of the patient; the degree of harmony or support which the family can provide the caregiver; the financial resources of the family; and the ability of both patient and family members to understand and cope with the changes which are occurring and their feeling about them.

Among the stressors which may complicate a situation or precipitate abuse are the presence of poor family relations in the past, serious problems of mental or physical impairment on the part of the patient and/or the caregiver; alcohol or drug abuse in either party; combativeness, incontinence, or wandering on the part of the patient; or feelings of being inadequate, overwhelmed, or unappreciated on the part of the caregiver. Also important to consider are any external stressors which may be present in the situation, such as family or marital problems, job loss, relocation, or changes in health status of other family members.

The manner of approaching the family and victim was considered. Professionals should avoid blaming either the victim or the abuser. Even if the abuse is repulsive, a provocative stance with the abuser alienates that person and may destroy the professionals opportunity to intervene. Care should also be taken not to overreact; for example, victims should not be removed from the home if less extreme interventions can succeed.

It is extremely important to develop a management plan for abuse and neglect cases. Case management is essential because abuse and neglect cases require a wide variety of services, involving not only the physicians, but also nurses and social workers, and possibly other professionals as well. Others may include a dentist, physical therapist, dietician, enterostomal therapist for management of skin conditions, home health care personnel, and others.

Case management is essential to coordinate the activities of

these professionals. The management task may be handled by the physician or a member of his/her staff. In some areas there are agencies which specialize in management of difficult cases. The management plan should include both short term and long term goals. Short term actions include the report to APS as well as assessment of the risk of imminent harm to the victim. If the physical safety of the victim is at risk, some action to protect the victim is of the highest priority. It is preferable to remove the abuser from the home if possible. Alternately, the victim may be removed from the situation. Emergency placement through Adult Protective Services or other state agency may be necessary.

In prior years, the victim was frequently placed under hospitalization for his/her own protection. With the introduction of the DRG system of hospital payment, it has become more difficult for physicians to use this method. There remain, however, means by which this can be done. Two DRG categories (Nos. 454 and 455) can be used for such injuries. However, these categories have low payment rates and are viewed with question by most utilization review personnel. They are more appropriate as co-morbidities. When used, it is essential that hospital personnel carefully document the injuries observed, treatments applied, etc. This is particularly true of services provided by auxiliary personnel, such as social workers.

Where the victim is not at immediate risk, in home protection or assistance may be sufficient. Assistance for the caregiver may be needed in order to reduce stress and provide training and

assistance in caregiving. For long term management, a wide variety of services may be required in order to stabilize the caregiving situation in the home.

The specific procedures to be used in reporting abuse were detailed. For example, reports of abuse should be handled in a different manner, depending upon where the abuse occurred. For example, abuse occurring in domestic settings should be reported to Adult Protective Services; but abuse in a nursing home should be reported to the Michigan Department of Health - Licensing and Regulation unit.

The representative of Adult Protective Services then detailed the manner in which the department handles the reports it receives. Workers are required to initiate an investigation within 24 hours. While the department seeks to protect the victim, it also recognizes the right of individuals to make their own decisions. If a competent adult refuses to accept the protection of the agency, they do not interfere.

At the same time, they seek to make the victim aware of a wide variety of services which may be available. They also attempt to include the family as much as possible, but where the needs and wants of the victim compete with those of the family, the needs of the victim take precedence. Since the APS presenter varied with the geographic area in which the Conference was presented, each presenter also included a discussion of the specific issues and problems which were prevalent in that area. This contribution was highly rated by attendees, as will be indicated in the evaluation

section.

Discussion of case histories then followed. Three cases were discussed. One was a cognitively impaired female being cared for by her husband, who was suffering severe caregiver stress and depression. He refused to obtain help in the home; as a result, she had experienced physical and psychological neglect, as well as financial abuse. The second case was a cognitively impaired woman living alone. Her conservator does not provide resources to maintain the home and reports that the woman has no funds, although she had over $30,000 two years ago. The victim's niece became concerned about her safety and the management of her affairs. Case number three is a widowed male with a history of polio being cared for by his sister-in-law. He is extremely physically disabled but mentally alert. He is left unattended for long periods of time and is psychologically abused in public by his caregiver.

Materials distributed in the case management session included not only the outline of the presentation, but also materials on the reporting of abuse (an overview of Adult Protective Services principles, the rights of victims, sample APS forms, etc.); the agency to receive reports of abuse, depending on the situation in which it is found; information on family strengths and stresses to be considered in working with victims and their families; and case histories to be used in group discussion which concluded the session.

Group discussion was generated both by the presentation of case histories and by the videotapes, which depicted both a wrong

and a better way of dealing with an alleged abuser. A common question was: should the physician inform the victim and/or abuser that a report to APS had been made? How can the report be presented in a positive rather than a negative manner?

PART V

PRESENTATION AND EVALUATION OF PHYSICIAN TRAINING MATERIALS ON ELDER ABUSE

Having developed the materials, the question of their effectiveness remains. Six Michigan Physicians' Conferences on Elder Abuse were scheduled for various sites, selected to cover the entire State. In this section we will describe the Conferences and present the results of the evaluation of the programs.

East Lansing Conference:

The first of the series of six Conferences was held on Wednesday, June 21, 1989, at the Michigan State University Clinical Center in East Lansing, Michigan. The training personnel included Dr. O'Brien and Dr. Sengstock, Mr. Thomas Trainer for the legal presentation, and Ms. Sue Haviland and Mr. Leon Schrauben for the Case Management presentation. One of the highlights of the first Conference was the presentation of Ms. Jan Baszler, a worker with Ingham County Adult Protective Services. She made an excellent presentation on the role of the State Department of Social Services in elder abuse cases.

Attendance, unfortunately was quite small (only 12), with 4 seeking Continuing Medical Education credits and submitting evaluations. While we were all disappointed with Conference attendance, the experience gave us an opportunity to observe the entire program and determine any areas which needed change. These

include the production of a new videotape on referral and case management, and several new slides, as well as alterations in the introductory, clinical identification, and case management presentations, in order to further clarify issues and avoid duplication. In keeping with a suggestion by one of the attendees, additional case material will be added to the presentations.

Marquette Conference:

The Marquette Conference was held at Marquette General Hospital in Marquette, Michigan, on August 11, 1989. Ms. Sue Haviland was unable to be present, so Mr. Schrauben handled the case management presentation alone. All other presenters were present. Mr. Val White, Adult Protective Services Supervisor, and Mr. Randy Haddis, APS worker, made the presentation for the Department of Social Services. Their presentation was enlivened by case histories of Adult Protective Services reports which have been investigated in the largely rural Upper Peninsula of Michigan.

There were eight attendees. While the numbers were small, we were pleased to see that the physicians attending were extremely concerned about the problem of elder abuse and were anxious to assume the physician's role in dealing with this problem.

Traverse City Conference:

The third Conference was held at the Munson Medical Center in Traverse City, Michigan, on September 9, 1989. Only 3 people attended this conference. It was the most disappointing attendance of any of the conferences. All regularly scheduled presenters were available for this Conference. Ms. Cathy Hamilton, APS Supervisor

for Grand Traverse County, made the APS presentation. In addition, one of her workers was present for the morning portion of the Conference.

As noted earlier, this conference was videotaped such that the Administration on Aging may have a permanent record of the content of the conferences. The APS portion of the tape, however, was replaced by a tape of Ms. Jan Baszler, the East Lansing APS worker from the first Conference.

Kalamazoo Conference:

The fourth Conference was held at Borgess Medical Center in Kalamazoo, Michigan, on September 21, 1989. In terms of attendance, this was the most successful of our conferences thus far, with 36 persons attending. We attribute the large attendance to the efforts of the staff of the Geriatric Assessment Center at Borgess Medical Center. Mr. Douglas Hall, the Director, and his staff members, Kathy Huss and Marlene Denenfeld, spent considerable time and effort advertising the Conference for us. We are convinced that this local effort is absolutely essential to a successful Conference.

Mr. Thomas Trainer, the developer and presenter for the legal issues presentation, was scheduled to be out of the country at the time of this Conference. Consequently, it was necessary to obtain a replacement for this presentation. Ms. Sharon Miller conducted the legal issues presentation in Mr. Trainer's absence. Ms. Miller is well qualified to handle this task. A Detroit attorney with extensive experience in the area of law and the elderly, she is

also a former social worker and holds a Certificate in Gerontology from Wayne State University. She teaches courses on senior citizens and the law for Wayne County Community College in Detroit, and was formerly associated with the Senior Citizens' Legal Aid Project in Detroit, which handled many cases of elder abuse. While there she also worked with Mr. Trainer and is familiar with the issues which he covers. Ms. Miller handled the presentation and resulting questions in a stimulating manner which was well received by the audience.

Grand Rapids Conference:

The fifth Conference was scheduled to be held at St. Mary's Health Services in Grand Rapids, Michigan, on October 19, 1989. This was the third Conference to be located in the west central portion of the Lower Peninsula of Michigan. However, after the Kalamazoo Conference, it was determined that we should not go to the expense of any additional Conferences, unless we were assured of a minimum attendance of 20 persons.

Since the Grand Rapids Conference had only 9 registrants during the week preceding the Conference, a decision was made to cancel it. Since two earlier Conferences had been held in this area, and the final Conference was still to occur in Detroit one month later, we believe that physicians in this portion of the State had the opportunity to attend if they so wished. In order to induce the registrants for this Conference to attend the remaining Conference, they were offered free registration if they chose to come to the Detroit Conference.

Detroit Conference:

The final Conference was held at Grace Hospital in Detroit on Wednesday, November 29, 1989. All the scheduled presenters were present for the Conference. Mr. Mark Nowakowski, Adult Protective Services supervisor for Wayne County, which includes Detroit, made the presentation for the Michigan Department of Social Services. Attendance was 22 persons, about half of whom were physicians.

EVALUATION

As indicated previously, attendees at each of the Michigan Physicians' Conferences on Elder Abuse were asked to complete a questionnaire concerning their estimate of the effectiveness of the Conference. The questionnaire was developed jointly by the Co-Principal Investigators and our evaluation consultant, Dr. Melanie Hwalek of SPEC Associates, with the input and advice of the Advisory Committee.

Once the content of the evaluation questionnaire had been developed, SPEC Associates prepared the questionnaire in its final format. The Conference staff then made copies which were distributed at each Conference. Care was taken in the development of the questionnaire to insure that all necessary information would be obtained. On the other hand, we wished to make the questionnaire short enough to insure that the majority of participants would complete the form. To accomplish this, our consultants suggested that the form should be limited to a single page.

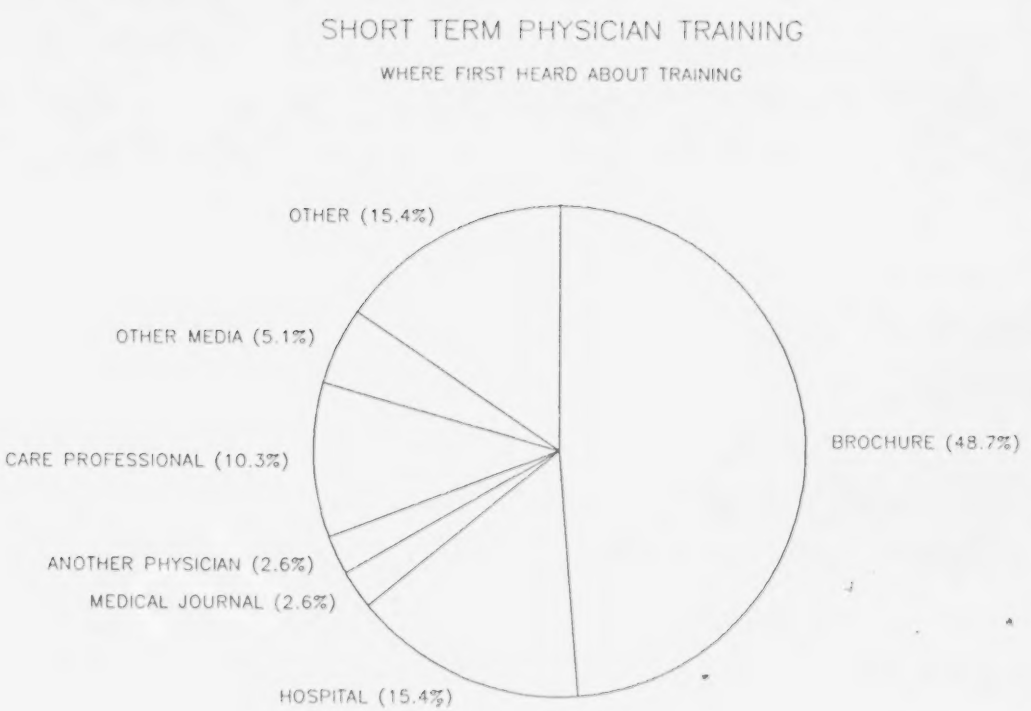
The resulting evaluation form asked each attendee to evaluate the conference overall, as well as each of the component parts. These parts included each individual lecture, as well as the videotapes and/or slides which were included in each presentation. Additional questions asked how they had learned about the Conference, how they anticipated that their practices might change as a result of it, and whether there were any additional information which they felt had been missing from the Conference. (See Appendix D for a copy of the evaluation questionnaire.)

Results have been tabulated for each individual Conference; these data are available in Appendix D of this Report. We have not reported these individual Conference data in this section, however. Here we concentrate on the cumulative data from the last four Conferences (the Marquette, Traverse City, Kalamazoo, and Detroit Conferences). The East Lansing Conference presents a special problem in terms of evaluation data. Since this was our first presentation, alterations were made in the presentations, videotapes, and slides as a result of this Conference. Consequently, the data from East Lansing would not be comparable to data from the other four. Hence we have omitted the East Lansing Conference from the cumulative data considered here.

Learning About the Conference:

In order to determine which technique for reaching physicians would be most effective, one of the questions asked where the attendees had learned about the Conference. As Chart 1 shows,

Chart 1


SHORT TERM PHYSICIAN TRAINING
WHERE FIRST HEARD ABOUT TRAINING
OTHER (15.4%)
OTHER MEDIA (5.1%)
CARE PROFESSIONAL (10.3%)
ANOTHER PHYSICIAN (2.6%)
MEDICAL JOURNAL (2.6%)
HOSPITAL (15.4%)
BROCHURE (48.7%)

nearly half of the attendees had learned of the Conference through our brochures. A hospital was the source of information for 15.4 percent of the attendees. Another 15 percent of the respondents learned of the training from some other medical source (10.3 percent from a health care professional other than a physician; 2.6 percent each from another physician or from a medical journal).

The remainder of the respondents (about 20 percent) reported having heard of the Conferences from a source outside the medical profession. Five percent had heard of the Conference from the media, other than a medical media source. And 15.4 percent mentioned "other" means of learning about the training. An analysis of the individual specifications of these responses indicated that most of the responses represented individual contacts with project staff members or literature in medical sources other than the medical journal (a newsletter, for example).

As indicated in our earlier section on organization, these results lead us to conclude that a direct mailing of brochures would be the most effective means of reaching physicians. Other medical sources, such as hospitals, or the medical journal or newsletters, are also of value. Even the "other" sources mentioned by some respondents tended to be personal contacts in the medical sphere or Conference staff. General sources, such as the mass media or personal contacts outside of medicine, are of little value.

Evaluation of Conference Content:

Turning to comments on the content of the Conference, we were pleased to learn that the attendees seemed extremely well satisfied. Chart 2 presents a summary of their opinions, on a scale in which 1.00 represents "poor," and 5.00 represents "excellent." As the Chart indicates, the session overall received an average rating of 4.08, which represents an overall rating of "very good."

We will now proceed to discuss the ratings received by each of the individual components of the training. The rating of the Introductory Lecture was approximately the same as the overall rating, receiving a score of 4.13; slides which were a part of the Introductory Presentation received a slightly lower rating of 3.79. The lecture on Clinical Diagnosis received a rating of 3.97; the associated videotape was rated 3.85, with the Clinical Diagnosis slides being rated 3.85.

The Legal Issues lecture was particularly well received, with the lecture receiving a rating of 4.42, the highest of any single item. The legal videotape received a 3.68 rating. The Case Management lecture was rated 3.88, with the videotape receiving a 3.79 rating. The Question and Answer Session, which immediately followed the Case Management Session, was rated 3.83.

Anticipated Changes in Medical Practice:

Attendees were asked to indicate the degree to which they believed they thought their practices would change as a result of

Chart 2

SPEC ASSOCIATES'
EVALUATION OF
WAYNE STATE UNIVERSITY'S
SHORT TERM PHYSICIAN TRAINING PROGRAM

CUMMULATIVE RESULTS

PROGRAM COMPONENT	POOR 1	FAIR 2	GOOD 3	VERY GOOD 4	EXCELLENT 5	NO RESPONSE -9	AVERAGE
OVERALL, THE SESSION WAS:	0	0	3	27	6	4	4.08
INTRODUCTORY LECTURE WAS:	0	0	4	26	9	2	4.13
INTRODUCTORY SLIDES WERE:	0	2	9	23	5	2	3.79
CLINICAL DIAGNOSIS LECTURE WAS:	0	0	7	23	6	5	3.97
CLINICAL DIAGNOSIS VIDEOTAPE WAS:	0	3	11	20	5	2	3.69
CLINICAL DIAGNOSIS SLIDES WERE	0	1	7	28	3	2	3.85
LEGAL ISSUES LECTURE WAS:	0	1	2	14	19	5	4.42
LEGAL ISSUES VIDEOTAPE WAS:	0	2	12	15	5	7	3.68
CASE MANAGEMENT LECTURE WAS:	0	0	8	22	4	7	3.88
CASE MANAGEMENT VIDEOTAPE WAS:	1	0	8	15	5	12	3.79
QUESTION AND ANSWER SESSION WAS:	0	1	6	19	3	12	3.83

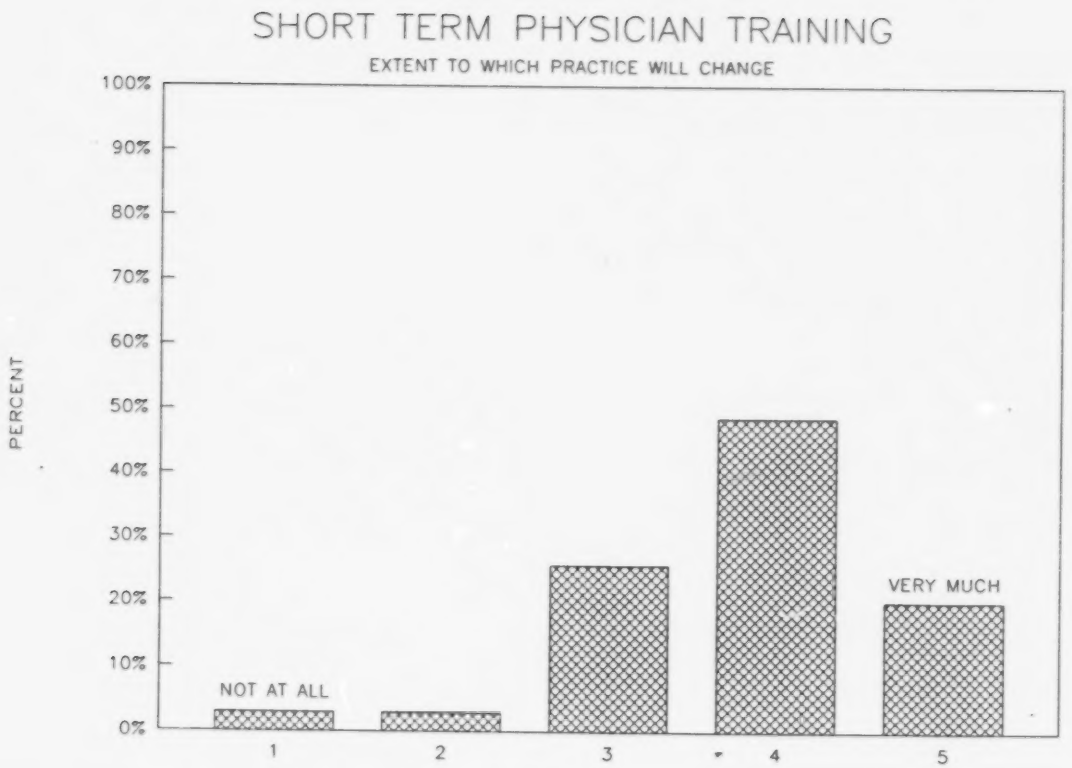
the training. The reader should be aware that not all of the attendees were physicians. Some may be practitioners in other health professions, but the questionnaire did not ask respondents to indicate their field. Hence all are included together here. As indicated in Chart 3, respondents generally seemed to believe the Conference would result in some changes in their practices.

Very few respondents reported that their practices would change little or none at all (these may have been persons who indicated they had already incorporated aspects of elder abuse identification into their practices). On a scale of 1 (indicating "not at all") to 5 (indicating "very much"), 26 percent of the respondents selected 3 (indicating some change), 49 percent selected 4, and 20 percent selected 5 (indicating that their practices would change "very much").

The most common way that the respondents felt that their practices were likely to change was in reference to their alertness to the problem of elder abuse and neglect and increased ability to identify the problem. Comments included statements such as the following: "more sensitive to elder abuse issues, more observant of possible abuse..."; "more knowledge, sensitivity, awareness"; "more observant..."; "more alert for signs of elder abuse ..."; "more aware of the possibility of elder abuse, how to inquire about it..."; "more alert to indicators of possible abuse/neglect...." One respondent summed up these views with the statement: "Now I know what to look for."

Other comments indicated that the respondents were

Chart 3


SHORT TERM PHYSICIAN TRAINING
EXTENT TO WHICH PRACTICE WILL CHANGE
PERCENT
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
NOT AT ALL
VERY MUCH
1
2
3
4
5

particularly appreciative of the specific information on the legal requirements and the procedures for reporting cases to the State agency. "More aware of legal issues..."; "Greater understanding of how APS works..." sums up the comments in this category. One respondent specifically noted that "Having local APS people talk was a fabulous idea." This comment came from the Marquette Conference, where the APS worker, Mr. Val White, provided a particularly vivid description of the unusual experiences of an APS worker in the predominantly rural counties of the Upper Peninsula of Michigan.

Since the major goal of the Conference was to encourage physicians to make reports to Adult Protective Services, it is encouraging to note that several respondents indicated that they would be more likely to report suspected cases of elder abuse or neglect as a result of their experience. One physician, who identified him/herself as associated with an emergency room, replied that s/he would be "... more likely to initiate DSS investigations" as a result of the Conference. Another indicated a "plan to report quicker." Still another stated: "I think I will report some neglectful care I have seen from nursing homes to the Public Health Department."

Several respondents indicated that they felt the interdisciplinary input provided by the COnference was particularly helpful. One comment noted that abuse and neglect cases are particularly difficult to manage, and the concept of "shared responsibility" was very helpful. Others noted that they would be

more aware of available resources, would understand the roles of other agencies, or would be enabled to coordinate the services of physicians and other health and social service personnel more effectively.

Other attendees noted that they felt better prepared to deal with specific situations as they arose, and how to refer if they suspected a problem. One respondent stated that s/he now felt more aware of family system concerns and means of keeping the victim in the home if possible. One physician noted that the Conference "... will help in my role as medical consultant for Visiting Nurse Association ..." in one of the regions of Michigan.

One particularly encouraging note was that several respondents indicated they planned to convey the information they had received to other professionals. One commented s/he planned to "will use this in educating other staff." Another stated s/he "will urge others to be more observant and take action when needed." And a respondent who identified him/herself as a clinical risk specialist, not a physician, planned to offer information on elder abuse and neglect to hospital affiliates as a part of a risk management program. Such comments encourage us to believe that the results of the Conference will continue and expand after the project is completed.

Suggestions for Improvement:

Some of the comments made by the respondents were suggestions as to ways in which the Conference or its components might have

been improved. Among the suggestions the respondents made were greater consideration of issues related to abuse in nursing homes; the inclusion of more specific case materials; and specific information about assessment tools, such as the depression screening instrument and mental status evaluation to which Dr. O'Brien had referred in his lecture. One respondent suggested there is a need for a "...shorter survey for high risk patients in emergency [settings]."

Attendees also asked for additional information about the abuser and victim. For example, one respondent suggested "more video of abuser and abused, how they think and act." Another stated, "I would have liked more information about who are the abused/abusers very early on in the first session, instead of one hour into the talk."

In terms of the form of the presentations, one respondent felt that "These lectures should have all been shortened considerably. The Q&A sessions should have been lengthened." Another felt that the medical part of [the lecture by the nurse and social worker should have been included in the lecture by Dr. O'Brien, since s/he felt it would have had more impact had it been presented by another member of the medical profession.

Overall Analysis:

All in all, however, most respondents had basically good reviews of the Conference. One stated that "A conference for physicians was a long time in coming." Other comments were:

"Excellent - a topic not taught in residency"; "Good overview (excellent in fact) of a timely topic..."; "What a great conference! Timely topic, excellent/knowledgeable speakers. Very good handouts. Thanks for the bibliography. Good lunch." A respondent who identified him/herself as being associated with the Department of Social Services commented that a similar training experience was needed for their own workers.

If there was a general criticism of the Conference which was shared by a number of respondents, it was the concern that the physicians who most needed to attend the Conference had not received information about it. As one respondent put it: "Somehow -- someway, this needs broader dissemination: Too many persons simply don't know about the law. Only one criticism, conference PR was very low profile. Physicians, I believe, were more likely than not to never have been aware. Should have made special effort to involve physicians-in-training." Another pointed to the "... Need to package [the materials] for use in CME [Continuing Medical Education] and physician education settings."

This concern was also illustrated by the comments of two respondents that the materials were really not new to them; they already knew about elder abuse and neglect and had incorporated this knowledge into their medical practices. What they had seen and heard had only confirmed this knowledge. While it was encouraging to know that some physicians are already knowledgeable about the problem, it is distressing to realize that the Conference very likely attracted primarily physicians who were already

acquainted with the problem, thereby missing those who most needed the information.

PART VI

DISSEMINATION OF INFORMATION

ABOUT THE PROJECT AND PROJECT MATERIALS

Throughout the project, the Co-Principal Investigators and project staff have made continued efforts to make known the existence of the Michigan Physicians' Conference on Elder Abuse, both to physicians and to the general public. Several of these efforts have been detailed in the publicity and public relations section of this report. In this section, we will concentrate on the efforts which have focused on the presentation of the actual substance of project materials, rather than simply publicity about the fact of the Conferences.

Dissemination of Project Materials in Past Months:

During the latter months of the project, both Principal Investigators appeared at various Conferences and meetings, making presentations in which all or part of the content was derived from the materials developed by the project. In such presentations, the speakers always insure that the Michigan Physicians' Conference on Elder Abuse, and the support of the Administration on Aging, is acknowledged.

The most significant opportunity to make a presentation of this type occurred in conjunction with the annual convention of the Michigan State Medical Society (MSMS), one of the co-sponsors of the project, which was held on Thursday, November 9, 1989, at the Hyatt Regency Hotel in Dearborn, Michigan. This conference

represented a major opportunity to reach physicians who might not ordinarily attend a full-day conference. Seizing this opportunity, Dr. O'Brien organized a session on family violence for the conference. Three of the project participants, Dr. O'Brien, Dr. Sengstock, and Attorney Thomas Trainer, made presentations at the session. We were joined by Dr. Clyde Owings, a physician from the University of Michigan and Mott Children's Hospital, who made a presentation on child abuse. The session attracted 13 attendees.

Throughout October and November, the Co-Principal Investigators had several opportunities to disseminate project materials. Dr. Sengstock made a presentation at the annual meeting of the Society for Applied Sociology, held in Denver, Colorado, from October 20 to 23, 1989. Dr. O'Brien conducted Medical Grand Rounds at St. Louis University in October, as well as making a presentation on family violence at the October, 1989, meeting of the American Medical Association. In November, Dr. O'Brien made a presentation on elder abuse to geriatric physicians and gerontologists at the annual meeting of the Gerontological Society of America in Minneapolis, Minnesota.

On February 13, 1990, Dr. O'Brien presented Medical Grand Rounds at the University of Hawaii, focusing on elder abuse. This presentation attracted a large audience, including social workers and nurses. The Chair of Medicine at the University of Hawaii was particularly pleased with the interest of these other health professionals.

Dr. O'Brien also arranged for a shortened version of the

Conference to be presented to medical staff and residents at St. Lawrence Hospital during their weekly staff training periods. It is the estimate of the Co-Principal Investigators that future use of the materials developed by our project may be more effective in drawing physicians if they are presented in shorter sections, such as these presentations to medical staff at lunch-hour sessions, or at general professional meetings.

On the 25th of March, 1990, three of the Conference presentations (the general introduction, and the presentations on clinical aspects and case management) were presented to the Second Annual Family Care Conference, held in Lansing, Michigan under the auspices of the Michigan State University Family Care Studies and College of Nursing and the Michigan State Office of Services to the Aging. Drs. O'Brien and Sengstock and Ms. Sue Haviland prepared and delivered these presentations.

We are still convinced that the presentation of a comprehensive packet of information on elder abuse and neglect, including materials on the types of abuse, clinical techniques of identification, legal issues, and case management, is the preferable method of informing physicians about elder abuse. However, our experience has proven their reluctance to attend sessions which extend over an entire day. Consequently, we believe it advisable that the materials from the project be packaged in such a manner that they could be used in a variety of formats. They could, of course, continue to be presented in concentrated format, as was the case with the Michigan Physicians' Conference

on Elder Abuse. But if time constraints prohibit this, they could be presented on an intermittent basis, such as at annual conventions, in-service training sessions at hospitals, or presentations to residents.

Future Dissemination Plans:

In connection with this goal, the Principal Investigators have developed plans in three areas. These include the development of an Physicians' Manual on Elder Abuse, which will summarize the procedures for identifying, reporting, and managing a case of elder abuse or neglect. This manual is planned to be a concise description of the steps to be followed in these cases.

Second, a modified version of this Physician Manual will be prepared for Physician Update, a publication of the Michigan State Medical Society. Mr. Tom Plasman of the Michigan State Medical Society staff has already assured us of the publication of this article when it is completed. Hopefully a draft of this material can be completed by the end of summer, 1990.

Finally, we have arranged with the Office of Medical Education Research and Development (OMERAD) at the Michigan State University College of Human Medicine to make the outlines, slides, and videotapes produced by the project available to physicians, residents, and medical schools throughout the State of Michigan and elsewhere. As indicated previously, Ms. Karen Lienhart, M.A., a Specialist on Instructional Product Development, and Therese deSpelder, both of the OMERAD office, are working with us on this

project.

The outline for this packet of materials has already been developed and is currently in preparation. The program will be entitled, Elder Abuse Assessment & Management for the Primary Care Physician. It will consist of the videotapes and slides which were prepared for the Michigan Physicians' Conference on Elder Abuse, together with some additional materials which are being developed specifically for this program. The resulting program will be marketed for us through the OMERAD office.

These new materials are handouts, suggested agenda, and overhead transparencies. They will be combined with the existing videotapes and slides to form a complete program for use by physicians and other health professionals to present their own conference on elder abuse assessment and case management. A copy of the outline for the program, together with a flyer advertising the package, has been included in Appendix E.

In accord with our belief that the training can be better utilized if presented in smaller segments, the program has been planned to encompass eight modules, as opposed to the four segments which were presented in the physicians' conferences in Michigan. The materials from the four presentations have been somewhat rearranged in order to make eight coherent but shorter presentations. In accordance with the evaluation responses, citing the need for more discussion of individual cases and question and answer time, increased opportunity for group discussion and analysis of cases has been included in the program.

The use of overhead transparencies has been included as a result of the experience of the OMERAD staff; they have found users to be more comfortable with the use of overhead projectors than slide projectors. Consequently, we plan to convert all textual slides to overhead transparencies. Only the photographic materials will be left in slide form. This also has resulted in the need for a reorganization of the materials to place all of the photographic slides in a single presentation.

A short description of each of the component parts of the program will illustrate the manner in which the materials have been rearranged and modified for use in training by physicians and other professionals.

Unit 1: This unit will be a lecture, designed to provide a general introduction to the problem of elder abuse, including the types of abuse and the unique role of physicians in dealing with this problem. Materials provided will include lecture notes, handouts, and overhead transparencies for use in presenting the lecture.

Unit 2: The focus of this unit will be on the recognition of patients at risk of abuse. it will include lecture materials, as well as a portion of the clinical identification videotape. Materials will include the videotape, lecture notes, and overhead transparencies.

Unit 3: This will focus on the actual identification of clinical symptoms of abuse. It will include lecture notes and a handout, developed from Dr. O'Brien's clinical identification

lecture. This will be the only unit which will include slides.

Unit 4: Unit 4 will deal with appropriate and inappropriate techniques for dealing with victims and alleged abusers. It will include the clinical interview section of the clinical identification video, as well as videotapes from the case management presentation. Handouts, lecture notes, and visual materials will also be included.

Unit 5: Legal issues will be the focus of this unit, including reporting requirements for Adult Protective Services, possible risk of lawsuits, confidentiality issues, and the like. The major component of this unit will be the legal issues videotape developed for the Michigan Conferences. Handouts and discussion notes will also be provided.

Unit 6: Common factors associated with elder abuse will be discussed in this unit. handouts, overhead transparencies, case materials for group discussion, and worksheets for use in discussion will be provided.

Unit 7: Unit 7 will focus on five case management principles for use in abuse cases, including: the use of APS as a helping intervention; identification of areas of agreement between patient and caregiver/abuser needs; identification of the physician's role; identification of the roles of other professionals; and identification of sources of support, including other human service providers. Materials will include handouts, visual materials, and case materials with worksheets.

Unit 8: The final section will continue the discussion of

case management, distinguishing between short and long-term management, problems involved in hospitalization, reimbursement, and so on. Lecture notes, handouts, and overhead transparencies will be included.

Conclusion:

In conclusion, we are pleased with the development of these materials for distribution through the OMERAD office. We believe they represent a significant means by which to continue to provide the results of our project to physicians and other health professionals in Michigan and elsewhere. We appreciate the efforts Ms. Lienhart and the OMERAD office have expended on our behalf. The Administration on Aging will be provided with a copy of the program when it has been completed.

Our planned Physicians' Manual and article for the Michigan State Medical Society's Physician Update have taken considerably longer to prepare than we would have liked. We had hoped to have them completed by the date of our Final Report. We plan to continue working on these products, however, hopefully completing them by the end of the calendar year, 1990. We will submit copies of the materials to the Administration on Aging as soon as they are completed.

PART VII

CONCLUSIONS AND RECOMMENDATIONS:

Our experience with the development and presentation of the Michigan Physicians' Conferences on Elder Abuse has lead us to a number of conclusions and recommendations on training for physicians on topics such as elder abuse. Most of these issues have been discussed in detail in earlier sections of this report. Here we will summarize our conclusions and reiterate our recommendations. They will be considered in five areas: the nature of materials for physician and other professional training; personnel involved in providing professional training; recommendations for the one day conference format; consideration of other conference approaches; and alternative approaches to training physicians.

Nature of Materials for Training Physicians and Other Professionals:

The Goal of Graphic Materials:

Most materials, such as slides, which have been used for training in the area of elder abuse have been selected for their "shock" value. That is, they are presented to audiences for the purpose of demonstrating the critical nature of abuse and neglect cases, and so generating concern for the problem. While this goal may be laudable as a means of generating interest on the part of persons who have no knowledge of abuse or neglect, it is of little value in training physicians. A few shocking cases may be

appropriate to generate attention. But for the most part, the goal for doctors, as well as other medical professionals, should not be to exhibit the worst cases of abuse or neglect, but to exhibit early symptoms, to illustrate means of identifying abuse or neglect in its earliest stages.

Recommendation 1: Photographs developed for training medical personnel, including physicians, should not be selected for shock value. Rather they should be focused primarily on the identification of abuse or neglect in its early stages.

Use of Videotapes:

The existence of videotape as a new medium has lead many people to turn to this form as a major means of training. It is not a substitute for other techniques, such as slides. Its value lies in its dynamic nature, i.e., its ability to illustrate process and to generate discussion. Videotapes should not normally be used to demonstrate static or motionless materials. For this reason, we made considerable use of slides to demonstrate contrasts between symptoms, for example, where the material lacked a dynamic nature. The relatively more expensive videotape form was reserved for material of a dynamic nature.

Recommendation 2: Audiovisual materials should be adapted to the material to be illustrated: videotapes for dynamic process, slides for depicting static contrasts.

Use of Case Materials:

When we began this project, we were well aware of the preference of physicians and other clinical specialists to focus on specific case histories in their training sessions. Consequently, we attempted to provide such a focus in the physician training. However, the evaluations still requested even more use of case materials. Hence we reiterate that individual case histories can seldom be overused.

Recommendation 3: The use of individual case histories in training physicians and other clinical professionals is one of the most valuable teaching tools available.

Distribution of All Testing Materials:

Several tests and measures were included in the presentations of the Michigan Physicians' Conference on Elder Abuse. A large number of these were included in the Conference packet. Others were provided as references. Several persons attending complained that some of these had not been provided. Conference developers should take care to insure that all measures to which reference is made are provided to the audience, preferably as handouts, but at least as reference sources.

Recommendation 4: All materials to which reference is made in presentations should be made available to the Conference audience.

Greater Emphasis on Question and Answer Sessions:

While time was provided for questions and answers, persons attending frequently indicated that they would have liked more time

to ask questions of the presenters. This is an important point for Conference organizers to keep in mind. We intend to handle this more effectively in the dissemination of materials from the Conference.

Recommendation 5: Considerable time for questions and answers between speakers and audience should be allotted.

Personnel Involved in Providing Professional Training:

In providing professional training, certain restraints in terms of personnel. These refer both to the makeup of the staff presenting the material, as well as the character of the audience.

Training by Professionals for Professionals:

A major principle which we attempted to follow in presenting the Michigan Physicians' Conference on Elder Abuse was to insure that this was training by physicians for physicians. While we used a number of trainers who were not physicians, we attempted to use them only in areas in which the presenter was dealing in his/her own area of expertise. Some conference participants commented, however, that the material on case management would have been better received if handled by a physician. Consequently, care should be taken to insure that the issues specifically related to an individual profession be handled by a member of that profession wherever possible.

Recommendation 6: As far as possible, training should be conducted by members of the profession being trained. Other professionals

should be used only where their specific expertise is required.

The Inclusion of Other Health Professionals:

On the basis of earlier experience indicating that physicians are reluctant to attend conferences open to other health personnel, we had originally planned to limit the Conference to physicians only. Other health professionals would be admitted only if attending as part of a physician's staff. This procedure proved to be highly divisive. ALlied health professionals are an important part of the health care team, and limiting attendance to physicians antagonized those health professionals likely to spend the greatest amount of energy on elder abuse cases. This approach may seem to conflict Recommendation 6, since it is difficult to provide training by professionals for professionals when several professions are involved. However, one profession can still be the primary target of the training. But other professionals can still be welcome if interested.

Recommendation 7: Conferences should be open to a broad range of interested personnel, not limited to a single profession.

Recommendations for the One Day Conference Format:

Given the plan to present a conference of the type illustrated by the Michigan Physicians' Conference on Elder Abuse, certain admonitions should be observed. We wish to mention four such issues.

Importance of Considering the Local Scene:

In our experience, the single most important factor in locating the Conferences was taking great care to consider issues of local culture. These include such factors as the most common day and time for professional training in the community and the status of the institution which will serve as the host for the Conference. As indicated previously, the institution should be highly regarded in the community and should not represent a deviation from major community values.

Recommendation 8: Training programs should follow local culture as much as possible, both in terms of practical issues such as conference timing, and community status and values.

Resources for Publicity:

With publicity as with training personnel, the most effective measures will be those in which professionals deal with members of their own profession. Techniques of reaching physicians were most effective when they were channeled through their own professional media. Other methods were a waste of time and money.

Recommendation 9: Publicity for professional training will be most effective when channeled through the profession's own resources.

Importance of Local Support:

Much as professionals resent being taught by outsiders, so also communities. In those areas in which the Conference was viewed as a presentation imposed from a state organization or outside university, response was poor. Our best response occurred

when a local group adopted the Conference as its own.

Recommendation 10: The support of a local organization is critical to the success of a training program.

Charging Physicians For Training:

We understand the policy of the Administration on Aging of requiring that professionals contribute to their own in-service training. In the Physicians' Conference, however, it proved to be a considerable disadvantage. This policy is reasonable if the training is in areas which are recognized as desirable by members of the profession. In the case of elder abuse, however, this is not the case. It is the opinion of others that physicians should be more knowledgeable in this area. But physicians neither want nor feel they need it. Consequently, charging for the training is counterproductive. On the contrary, every possible inducement should be used to entice them to attend.

Recommendation 11: When an area of professional training is one which members of the profession are not convinced of the value of an area of training, there should be no charge for the training. IN fact, techniques should be developed to entice the members to attend.

Consideration of Other Conference Approaches:

The reception accorded the Michigan Physicians' Conference on Elder Abuse was certainly less than optimum. We believe that this may be a factor of the format. A one day conference required that

the physician leave his/her practice for an entire day, or give up the only day of leisure available in the week. This may have deterred a number of physicians who might otherwise have been interested. Consequently, we suggest that other avenues for presenting this materials to physicians should be attempted.

Presentation of Training at the Request of the Institution:

Our experience with the Kalamazoo conference has illustrated the importance of local community support in generating attendance at the conferences. Consequently, it may be more effective if we make the existence of the training known, and indicate that the project staff will be willing to provide such training if hospitals or other community institutions request it.

Recommendation 12: Training programs may be more effective if they occur at the behest of a local institution. Such programs should be made available to hospitals, possibly through a university or medical society.

Presentation on an Extended Time Basis:

Many hospitals have established programs which provide in service training to physicians through programs which occur for approximately an hour per week. In this manner, the physician need not lose an entire day from his/her practice. Consequently, it may be possible to attract more physicians if the training program were held for one hour each week extended over a longer period of time. Again, this is particularly true of areas of training for which

physicians themselves see little value.

Recommendation 13: Training programs for physicians should be scheduled such that the minimum amount of time is taken from the medical practice. Programs can be divided such that they require only one hour per week, extended over several weeks or months.

Presentations in Convention Settings:

Another in-service training technique which least interferes with professional practice is the session at the profession's annual convention. Many professionals plan to attend such meetings as a regular professional activity. The Conference staff's presentation at the annual Michigan State Medical Society Convention is an example. Such programs may be more acceptable than special programs requiring exceptional plans.

Recommendation 14: Training programs will probably be more successful in attracting professionals if held in conjunction with the profession's annual convention.

Programs Available for Institutional Use:

There are relatively few professionals with the expertise to present a medical conference on elder abuse. At best, such persons would be able to reach only a small percentage of physicians. The materials developed through this program should be made available in a format which can be used by other.

In fact, programs may be more effective if they are presented not only by other professionals, but by persons from the local

area, who are well known to their colleagues in the community. INterested and committed professionals could be provided with the proper background for providing such training to their colleagues.

To this end, we have planned to package the materials from the Michigan Physicians' Conference on Elder Abuse, through the Michigan State University Office of Medical Education Research and Development, and make them available to professionals who would like to use them in this manner. We believe that this will be the most effective means of disseminating the materials from the Conference.

Recommendation 15: Materials on critical medical issues can be used more effectively if packaged in such a manner that they are no longer dependent upon the original developers, but can be used by other professionals for the conduct of in-service training.

Alternative Approaches to Training Physicians:

The experience of the Michigan Physicians' Conference on Elder Abuse suggests that any type of conference may not be the most effective method for in-service training for physicians. Even the most successful conference reaches only a small segment of the profession. Alternative approaches might be developed which might reach larger segments of the medical profession. We suggest two of these.

Articles in Professional Journals:

Larger numbers of physicians might be reached through the

medium of the professional journal. A series of articles which provide the same material presented in the conferences might reach more physicians in this manner.

Recommendation 16: Critical information on issues such as the identification and management of elder abuse might reach more physicians if serialized in the major professional journals.

Physician Manual:

Even for physicians with great concern for the problem of elder abuse, the occasional conference or article on the subject, however organized or presented, does not provide information at the most critical time. There is a critical need for information in a concise form, that can be made available to the physician for use when s/he encounters a case of suspected abuse or neglect. Such information might be more effective than conferences of any kind, since the material from the conference may have been forgotten by the time a case of abuse or neglect is encountered. We are now in the process of developing such a manual from the materials the project has developed.

Recommendation 17: Concise descriptive materials which can be kept easily at hand may be more valuable training for physicians than conferences which occur in isolation.

Summary of Recommendations:

Some of the recommendations provided here may be valuable for others who might wish to develop future in-service training

programs, not only for physicians but also for other professionals. Recommendations 1 through 14 fall into this category.

Other recommendations, however, relate more to the most effective manner of providing in-service training to professionals, particularly in areas for which the members of the profession have little relish. We refer here to Recommendations 15 through 17. These represent ways in which materials developed through this or other programs can extend far beyond the geographic limits of the original program.

To the extent possible, the Principal Investigators of the Michigan Physicians' Conference on Elder Abuse intend to make use of the media of professional journal articles, a physicians' manual, and the dissemination of the program materials to improve recognition and management of elder abuse in the medical profession.

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LIST OF APPENDICES

Appendix A: Map Showing Location of Conferences

Appendix B: Brochure and Flyer for Conferences

Appendix C: Agenda and Outlines for Conferences

Appendix D: Evaluation Questionnaire and Data from Conferences

Appendix E: Dissemination Plans for Program

Appendix F: List of Other Materials in Conference Packet

APPENDIX A:

Map Indicating Regions of the State
and Locations Selected for the
Michigan Physicians' Conference on Elder Abuse

Map of Michigan

Showing Regions and Location of Michigan Physicians' Conferences on Elder Abuse

APPENDIX B:

Sample Brochure and Flyer for the

Michigan Physicians' Conference on Elder Abuse

Item 1: Flyer

Item 2: Brochure

(double sided, folded in three)

ANNOUNCING

MICHIGAN PHYSICIANS' CONFERENCE ON ELDER ABUSE

TOPICS TO BE ADDRESSED:

- ❒ information on Michigan's mandatory reporting laws for physicians
- ❒ clinical techniques for assessing abuse and/or neglect
- ❒ evaluation of clinical signs and symptoms of abuse/neglect as opposed to normal aging
- ❒ list of appropriate referral agencies for physicians

OBJECTIVES: PARTICIPANTS WILL BE ABLE TO:

- ❒ distinguish the six types of elder abuse and neglect
- ❒ understand the dynamics of elder abuse and neglect
- ❒ recognize the clinical symptoms of abuse/neglect and distinguish abuse/neglect from normal aging
- ❒ understand the legal mandate to report abuse and the legal consequences of reporting or not reporting
- ❒ clarify case management techniques for elderly victims of abuse/neglect and identify agencies and services for referral

THE CONFERENCE WILL BE PRESENTED AT SIX SITES THROUGHOUT THE STATE

- MSU Clinical Center, East Lansing, June 21, 1989
- Marquette General Hospital, Marquette, August 11, 1989
- Munson Medical Center, Traverse City, September 9, 1989
- Borgess Medical Center, Kalamazoo, September 21, 1989
- St. Mary's Health Services, Grand Rapids, October 19, 1989
- Grace Hospital, Detroit, November 29, 1989

Wayne State University

Sponsored by:

Administration on Aging,
Office of Human Development Services,
U.S. Department of Health and Human Services
Geriatric Education Center of Michigan
Michigan State Medical Society
Michigan State University
State Office of Services to the Aging
Wayne State University

Additional Information

Mick Goldynia
Geriatric Assessment Center
St. Lawrence Hospital
1210 W. Saginaw
Lansing, MI 48915
(517) 377-0330

CONFERENCE FACULTY

Partial list of scheduled conference faculty include:

James G. O'Brien, M.D.
Director, Geriatric Education Center of Michigan
Professor
Michigan State University

Mary C. Sengstock, Ph.D., C.C.S.
Certified Clincial Sociologist
Professor
Wayne State University

Thomas Trainer, J.D.
Attorney
Chair, Senior Justice Committee
State Bar of Michigan

Sue Haviland, R.N.C., M.S.N.
Clinical Nurse Specialist, Gerontology
Saint Lawrence Hospital
Geriatric Assessment Center
Michigan State University

Leon Schrauben, M.S.W., A.C.S.W.
Medical Social Worker, Gerontology
Saint Lawrence Hospital
Geriatric Assessment Center
Michigan State University

Representatives of Adult Protective Services
Department of Social Services
State of Michigan

Michigan Physicians' Conference on Elder Abuse
Office of Continuing Medical Education
D132 West Fee Hall
Michigan State University
East Lansing, Michigan 48824

MICHIGAN PHYSICIANS' CONFERENCE ON ELDER ABUSE

● *Six conference sites*
June through November, 1989

Wayne State University

Sponsored by
Administration on Agin
Office of Human Development Servic
U.S. Department of Health and Human Servic
Geriatric Education Center of Michiga
Michigan State Medical Socie
Michigan State Universit
State Office of Services to the Agin
Wayne State Universit

Side 1

MICHIGAN PHYSICIANS' CONFERENCE ON ELDER ABUSE

PROGRAM OVERVIEW

These Conferences on Elder Abuse will be presented at six sites throughout Michigan. Topics to be addressed include: information on Michigan's mandatory reporting law for physicians; clinical techniques for assessing abuse or neglect; and clinical symptoms of abuse and neglect as opposed to symptoms of normal aging. Physicians will also be provided with a list of appropriate referral agencies. This conference is intended primarily for physicians, as leaders of the health care team. Since an interdisciplinary team approach is highly valuable in abuse or neglect cases, provision has been made for allied health professionals to accompany a physician as a team member.

OBJECTIVES

At the conclusion of the program participants will be able to:

- ❒ distinguish the six types of elder abuse and neglect
- ❒ understand the dynamics of elder abuse and neglect
- ❒ recognize the clinical symptoms of abuse/neglect and distinguish abuse/neglect from normal aging
- ❒ understand the legal mandate to report abuse and the legal consequences of reporting or not reporting
- ❒ clarify case management techniques for elderly victims of abuse/neglect and identify agencies and services for referral

ACCREDITATION

Michigan State University College of Human Medicine, accredited by the Accreditation Council for Continuing Medical Education, certifies that this program meets the criteria for six (6) credit hours of Category I of the Physician's Recognition Award of the American Medical Association.

ACKNOWLEDGEMENTS

This project was supported, in part, by award number 05AM9045, provided for the development of elder abuse training for physicians, by the Administration on Aging, Office of Human Development Services, U.S. Department of Health and Human Services, Washington, D.C.

CONFERENCE INFORMATION

Locations of Conference Sites

The Conference will be presented at the following sites throughout the state:

MSU Clinical Center Auditorium East Lansing, Michigan 48823	Wednesday, June 21 8:00 a.m. - 5:00 p.m.
Marquette General Hospital 420 W. Magnetic Marquette, Michigan 49855	Friday, August 11 8:00 a.m. - 5:00 p.m.
Munson Medical Center 1105 Sixth Street Traverse City, Michigan 49684	Saturday, September 9 8:00 a.m. - 5:00 p.m.
Borgess Medical Center 1521 Gull Road Kalamazoo, Michigan 49001	Thursday, September 21 8:00 a.m. - 5:00 p.m.
St. Mary's Health Services 200 Jefferson Street S.E. Grand Rapids, Michigan 49503	Thursday, October 19 8:00 a.m. - 5:00 p.m.
Grace Hospital 18700 Meyers Road Detroit, Michigan 48235	Wednesday, November 29 8:00 a.m. - 5:00 p.m.

CONFERENCE FEES

Registration fee includes continental breakfast, lunch, refreshment breaks and course materials.

$50.00 Physicians
$30.00 Allied Health Professional, accompanying a physician attending the conference
$15.00 Medical residents, interns, and students

REGISTRATION DEADLINE

Registrations will be accepted up to one week prior to the scheduled conference date.

Additional Information:

Contact: Mick Goldynia
Geriatric Assessment Center
St. Lawrence Hospital
1210 W. Saginaw
Lansing, MI 48915
(517) 377-0330

REGISTRATION INFORMATION

If you plan to attend the Michigan Physicians' Conference on Elder Abuse, please complete this advanced registration form and send with your check to:

Michigan Physicians' Conference on Elder Abuse
Office of Continuing Medical Education
D132 West Fee Hall
College of Human Medicine
East Lansing, Michigan 48824-1316

PREFERRED SESSION: (check one)

- ❒ MSU Clinical Center, East Lansing, June 21, 1989
- ❒ Marquette General Hospital, Marquette, August 11, 1989
- ❒ Munson Medical Center, Traverse City, September 9, 1989
- ❒ Borgess Medical Center, Kalamazoo, September 21, 1989
- ❒ St. Mary's Health Services, Grand Rapids, October 19, 1989
- ❒ Grace Hospital, Detroit, November 29, 1989

NAME _____

ADDRESS _____

CITY _____

STATE _____ ZIP _____

OCCUPATION _____

BUSINESS PHONE NUMBER (___) _____

Please pre-pay registration fee; make checks payable to:
MICHIGAN STATE UNIVERSITY

Michigan State University and Wayne State University are Affirmative Action/Equal Opportunity Institutions

APPENDIX C:

Agenda, Outlines of Presentations, and Bibliography Distributed to Conference Attendees

Item 1: Sample Agenda from the Detroit Conference

Item 2: Outline for the Introductory Presentation

Item 3: Outline for the Clinical Presentation

Item 4: Materials for the Legal Presentation

Item 5: Outline for the Case Management Presentation

Item 6: Materials for the Case Management Session:

- "Reporting Protocol"
- "Family/Caregiver Dynamics"
- "General Approach to Intervention ..."
- "Adult Protective Services Materials"
- "Case Histories"

Item 7: Bibliography Distributed to Attendees

PHYSICIANS' CONFERENCE ON ELDER ABUSE
GRACE HOSPITAL
18700 MEYERS ROAD
DETROIT, MICHIGAN
WEDNESDAY, NOVEMBER 29, 1989

OUTLINE OF PRESENTATIONS

8-8:30	REGISTRATION AND CONTINENTAL BREAKFAST
8:30-10	LECTURE #1 "INTRODUCTION TO ELDER ABUSE" PRESENTER: MARY CAY SENGSTOCK, PH.D., C.C.S. PROFESSOR OF SOCIOLOGY WAYNE STATE UNIVERSITY
10-10:15	BREAK
10:15-11:45	LECTURE #2 "CLINICAL IDENTIFICATION OF ELDER ABUSE" PRESENTER: JAMES G. O'BRIEN, M.D. DIRECTOR, PROGRAMS ON AGING COLLEGES OF HUMAN AND OSTEOPATHIC MEDICINE MICHIGAN STATE UNIVERSITY
11:45-1	LUNCH
1-2:30	LECTURE #3 "LEGAL ISSUES IN TREATING ABUSED ELDERS" PRESENTER: THOMAS TRAINER, J.D. CHAIR, SENIOR JUSTICE COMMITTEE STATE BAR OF MICHIGAN
2:30-2:45	BREAK
2:45-4:15	LECTURE #4 "EFFECTIVE MANAGEMENT: ASSESSMENT AND RESOURCES" PRESENTERS: SUE HAVILAND, R.N., M.S.N. CLINICAL NURSE SPECIALIST/GERONTOLOGY LEON SCHRAUBEN, M.S.W., A.C.S.W. MEDICAL SOCIAL WORKER/GERONTOLOGY GERIATRIC ASSESSMENT CENTER ST. LAWRENCE HOSPITAL LANSING, MICHIGAN MARC NOWAKOWSKI, SUPERVISOR DEPARTMENT OF SOCIAL SERVICES WAYNE COUNTY STATE OF MICHIGAN
4:15-4:45	CASE EXAMPLES AND RESPONSES (AUDIENCE PARTICIPATION INVITED)
4:45	ADJOURNMENT

ACKNOWLEDGEMENT:

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LECTURE: GENERAL INTRODUCTION TO ELDER ABUSE FOR PHYSICIANS

Objectives:
1. To provide a general introduction to the nature and types of elder abuse.
2. To acquaint physicians with some of the major factors which may be associated with elder abuse.
3. To suggest some approaches to assisting elderly abuse victims, through identification, referral, and assistance to both family and victim.

CAUTION: Most research on the subject to date has been based on small samples of cases already known to agencies. All results, therefore, must be considered highly speculative.

HISTORY OF ELDER ABUSE AS A PUBLIC HEALTH ISSUE
- Long Existing Problem
- Recent Focus (Approximately 1978)
  - Concern with Family Violence in General
  - Increase in Aging Population
  - Concern for Aged Victims of Family Abuse
- Increased Elder Abuse Research (1978 - present)
- House Select Committee on Aging (1981 Report)
  (Key Members: Claude Pepper, Fla.; Mary Oakar, Ohio)
- Attempt to Survey Elder Abuse in Population (Boston, 1985)
- NARCEA Founded by Administration on Aging (1988)
  (National Aging Resource Center on Elder Abuse)
- 38 States with Adult Protective Services Laws (1989)

DEFINITION OF ELDER ABUSE -- 6 TYPES:

	Psychological Neglect (social isolation)
	Psychological Abuse (verbal assaults)
Exploitation	Violation of Personal Rights (force/prohibit behavior)
Exploitation	Material Abuse (theft or misuse of property)
	Physical Neglect (failure to provide physical necessities)
	Physical Abuse (direct assaults) (incl. sexual assault)

Note: Family often in conflicting position -- choice between 1 type of abuse and another
(EX: Mother living alone in large house, refuses to move; don't force mother to move ... but later someone might accuse you of neglect!)

STATISTICS ON ELDER ABUSE:

Frequency of Elder Abuse:
Rate of Personal Crime against Aged: 12.44/1,000
1/5 knew offender --> 2.49/1,000 Abuse by Family
Block & Sinnott (1979): Rate of Abuse by Family = 6.772/1,000
Pillemer & Finkelhor (1988): Rate of Abuse = 32/1,000
Mich State Reports: Total APS Cases Opened Per Year:
1986: 5,870 1987: 6,027 1988: 5,678
(Approx. 56% are 60+; approx 25% are 70+)

Most Frequent Type of Abuse:
Varies with the Study:
Block & Sinnott (1979) ..... Psychological Abuse
Lau & Kosberg (1978) ..... Physical Abuse
Douglass & Hickey (1980) ..... Neglect
Gioglio (1983) ..... Financial Abuse
Sengstock & Liang (1982) ..... Financial Abuse

UNIQUE ROLE FOR PHYSICIANS IN IDENTIFYING ELDER ABUSE:
- More Elderly See Physician Than Any Other Professional
- Elderly Trust Physicians Than Any Other Professional
- Physicians Have Access to Critical Tests of Abuse
- Physicians Can Be A Critical Resource to Other Professionals

FAMILY CARE OF THE ELDERLY: THE POSITIVE SIDE:
- 75% of Elderly Have Family Nearby (<30 Minutes Away)
- Most Frequent Source of Support for Elderly Needing Help
- Physicians Report That Family Frequently/Always Participate in Discussion of Care of the Elderly

FAMILY CARE OF THE ELDERLY: THE NEGATIVE SIDE:
ELDER ABUSE CASES: THE ROLE OF THE PHYSICIAN
Survey by James G. O'Brien, M.D. (1984)
Sample: Primary Care Physicians (Internal Medicine, Family Practice)
Michigan: Mandatory Reporting for Professionals
(Physicians exempted in 1984)
North Carolina: Mandatory Reporting for Professionals
(Physicians Included)

FINDINGS:
- 17.9% Saw at Least 1 Case of Elder Abuse
- 20.7% Saw Cases in Which Abuse Was Suspected, Not Confirmed
- Types of Abuse Seen Included:
  - Neglect 79.9%
  - Psychological Abuse 61.1%
  - Physical Abuse 43.1%
  - Abandonment 34.5%
- 95.6% Had No Standard Procedure for Detecting Abuse
- 87.2% Considered Abuse Difficult/Very Difficult to Detect
- 83.5% Were Unaware There Were Laws Requiring Reporting

MEDICAL CONSEQUENCES OF ELDER ABUSE:

- Can Cause Trauma Which Aging Bodies Are Less Able to Handle
- Can't Get Prescribed Food or Medicine Because of Neglect
- Can't Pay for Medicine or Doctor Fees Due to Financial Abuse
- Don't Get Well Because of Depression over Abuse/Neglect
  (Similar to "Failure to Thrive" in Infants)

EXAMPLES OF THE 6 TYPES OF ABUSE
AS WELL AS THEIR CONSEQUENCES
WILL BE PROVIDED

MAJOR FACTORS ASSOCIATED WITH ELDER ABUSE:

Demographic Characteristics of Victims:
- More Women Victims (of course!)
- Higher Rate for Men? (Pillemer)
- Crosses Economic, Racial, Religious Lines
- High Rate for Incapacitated Elders? (Rosalie Wolf)
- Can Occur with Fully Competent Elders

Characteristics of Abusers:
- Gender of Abuser:
  - May Be Males or Females
- Relationship to Victim:
  - Caretakers
  - Sons and Daughters
  - Spouses
  - Other Relatives
  - Neighbors, Landlords, and Others
  - May be Financially Dependent on the Victim

Demographic Changes:
- Increased Number of Elderly
- Decreased Number of Children to Provide Care
- Changes in Family Structure
  - Families Dispersed Geographically
  - Fewer Women Remaining in Home
- Cost of Medical Care for Aged
  (Problem Worsens with DRGs)

Developmental Stages:
- Changes in the Aged Person's Life
  - constantly increasing dependency
- Changes in the Caretaker's Life
  - Menopause - Retirement - Aging!
  - Caregiver Burnout

Characteristics of Relationships in the Family:
- Substance Abuse or Mental Illness
- Previously Strained Relationship
- Long Term Violence in Family

Effect of Caregiving on Family Relationships:
- Disturbs Long Standing Power & Status Patterns
- Requires Violation of MAJOR Family Sexual Taboos
- Tensions of Three Generational Living

APPROACHES TO ASSISTING ELDERLY ABUSE VICTIMS:

Problems of Identification:
- Agency Dependence on Self Reports
- Attempts of Victim, Family to Hide Abuse
- Similarity of Symptoms: Abuse vs. Normal Aging
- Advantages and Disadvantages of Mandatory Reporting

Services for Aged Victims
- Wide Variety of Services Needed
  - (Medical, Legal, Counseling, Shelter, etc.)
- Availability is Limited
  - Coordination and Referral is Difficult

Need to Assist the Family with Caregiving is Essential
- Respite care
- Financial assistance
- Family Services Are Decreasingly available!

SUPPLEMENTARY READING

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ELDER ABUSE: CLINICAL ASPECTS

Physicians have been identified by some authors, such as Kosberg and Hickey, as being strategically placed to identify and intervene in elder abuse cases. It is known that medical facilities are the most frequently used sites after abuse has occurred. Despite this fact, it appears that physicians lag significantly behind nurses and social workers in reporting abuse.

OBJECTIVES:

1. To provide a rationale for screening and identification of abuse.

2. To demonstrate how detection of abuse can be integrated into a primary care model of practice.

3. To review methods of identification of abuse including symptoms, signs and other indicators in practice settings.

4. To discuss some initial management strategies that can be utilized in addressing the problem.

RATIONALE:

Elder abuse is an important problem for physicians to concern themselves with for a number of reasons. It would appear to meet criteria identified by Frame and Carlson for screening for a particular disease, given the prevalence, morbidity and mortality of abuse and the attendant effects on the quality of life.

Prevalence of abuse is not well defined based on community surveys but probably affects 3%-4% of community dwelling elderly; this figure may be higher in medical settings.

CRITERIA (Frame and Carlson):

1. The prevalence of a disease/problem should be adequate to warrant screening.

2. Known treatments should be available.

3. Treatment during earlier stages should provide a better outcome than that provided during later stages.

4. Acceptable methods of screening should be available.

5. The problem/disease should cause significant morbidity and mortality.

6. Disease should have an asymptomatic period.

Elder abuse seems to meet most, if not all, these criteria.

Principles of Geriatric Care (Kennie):

It is important that the problem of elder abuse "fit" in a practice setting and that most principles of geriatric care have application in addressing abuse.

1. Emphasis on maintaining and restoring function
2. Broadened assessment
3. Continuity of care
4. Specific knowledge
5. Maintain support system
6. Cautious intervention
7. Patient advocacy
8. Community orientation
9. Time for recovery
10. Legitimacy of death

HIGH RISK PROFILE:

VICTIM:

Dependent
Isolated
Demented
Behaviors - wandering
- belligerent
- pursuing
- not sleeping
Stress
Sudden decline in function
Failure to thrive
Use of many medical facilities especially emergency rooms
Non-compliance/no-shows
Depression
Delay in treatment

ABUSER:

Prolonged caregiving
Previous abuse
Refusal of help
Solo caregiving
Alcoholism/substance abuse
Heavy burden of care

Abuse does occur in situations that lack high-risk indicators. Vigilance and maintaining a high index of suspicion are prerequisites to identification of abuse. Elder abuse like many diseases in old age is underreported. Elder abuse often presents in multiple forms so that when physical abuse is present typically psychological abuse, violation of rights are also evident.

APPROACH: Modification Sengstock Hwalek Index.

SCREEN:

1. Are you sad or lonely often?
2. Do you have a critical support person to take you to the doctor?
3. Are your finances adequate?
4. Do you support someone?
5. Do you take your own medicines and manage your own A.D.L.S.? Describe a typical day.
6. Do you have enough privacy in your home?
7. Are you uncomfortable with anyone in your family?
8. Who makes decisions about your life - how/where you live?
9. Does anyone in your family drink a lot or have problems with drugs/medicines?
10. Any recent injuries, hospitalizations, E.R. visits?

CASE FINDING:

1. Has anyone tried to hurt or harm you recently?
2. Have you been forced to do things you did not want to do?
3. Does someone tell you you are ill or make you stay in bed against your will?
4. Has someone taken things against your will?
5. Does anyone tell you you are not wanted around?
6. Have you been threatened with placement in a nursing home?

SUSPECTED ABUSE:

INTERVIEW VICTIM:

1. Quiet private setting
2. Assure confidentiality
3. Separate interviews
4. Establish trust and rapport, non-threatening
5. Non-judgmental empathic approach
6. Allow adequate time for expression
7. Direct specific questions; Have you been struck, raped?
8. Accurate documentation
9. Establish imminent danger; urgency

INTERVIEW CAREGIVER/ABUSER:

1. Non-judgemental, non-threatening
2. Corroborate report
3. Estimate burden of care
4. Stresses
5. Typical day
6. Future plans
7. Other supports
8. Behavior, responses, appearance

PHYSICAL:

1. Mental Status Determination: Formal/informal M.M.S.E./ S.P.M.S.Q.

2. Depression Screen: G.D.S. behaviors

3. Functional Status: A.D.L. office A.D.L.

4. Appearance: Hygiene, clothing, wasting, emaciation.

5. Vital Signs:

   Pulse B.P. < recumbent / standing Temp.

   Height Weight Recent Weights

6. Aids/Prosthetics: Walker, cane, dentures, glasses, hearing aids, braces

7. Skin: Abrasions, bruises - stage, type, configuration, location; decubiti, dehydration, rashes.

8. HAIR: Lice, hygiene, pulled, boggy scalp.

9. MOUTH: Mucous membranes, vitamin deficiency, dryness, dental hygiene.

10. NOSE: Fracture, deviation.

11. NECK: Bruising.

12. CHEST: Bruising, underarms, breasts. Deformity, rib tenderness.

13. ABDOMEN: Soft tissue injury, tenderness.

14. PERINEUM: Bruising, bleeding, sexual assault.
    RECTAL: Gaping, impaction, proctitis.

15. EXTREMITIES: Range of motion, edema, deformities, tenderness.

16. COMPLETE EXAM: To look for hidden injuries.

17. DOCUMENTATION: Including photographs, diagrams.

SUPPORTIVE INVESTIGATIONS: As indicated.

LAB:	CBC SMAC Sed Rate Urine Serum Levels
X-RAYS:	Specific Screening old fractures.
SCANS:	C.T./other
REFERRALS:	As indicated

INTERVENTION: Mandated reporting.

Categorize abuse based on function of abused and amount of caregiving by abuser.

Establish risk of imminent harm. Consider short term placement D.R.G. for abuse.

Family Systems Approach.

Ethical Issues
If no coercion and competent desires of victim paramount.

OBJECTIVE FUNCTIONAL ASSESSMENT

Routine Items to be Noted	Recorded By
Responding to name in waiting room	Nurse/receptionist
Ability in transferring	Nurse/receptionist
Follows clues to proper room direction	Nurse
Undressing/shoe removal	Nurse
Ability to read scale/height	Nurse/physician
Mobility on exam table	Physician
Communication/social skills during exam	Nurse/physician
Writing down medication instructions	Nurse/physician
Following departure instructions	Nurse/receptionist
Ability to handle billing procedures	Nurse/receptionist

Added Factors in Selected Cases	Noted By
Lock and key use	Nurse/physician
Telephone use	Nurse/physician
Ability to maneuver a wheelchair	Nurse/physician
Correct money transaction skills	Nurse/physician
Stair mobility (if available)	Nurse/physician

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LEGAL DIMENSIONS OF ELDER ABUSE

Michigan and 37 other states have Adult Protective Services laws which seek to prevent or remedy the abuse or neglect of persons unable to care for themselves. These laws indicate a societal determination that abuse of the elderly and of other vulnerable people will not be allowed, and that state government will protect those in need. To learn of problems requiring intervention, states frequently require persons in certain professions to bring reports of suspected abuse or neglect to the attention of the appropriate authorities, generally the local Department of Social Services or Aging. In Michigan, and in a number of states, physicians are included in the professions mandated to report abuse or neglect.

I. What does the Michigan APS law (MCIA 400.11 et seq) seek to prevent?

Abuse, endangerment, exploitation, and neglect (Sec 11). These terms encompass what we commonly refer to as "elder abuse" or "abuse and neglect" (hereafter generically referred to as "abuse"), and are defined in the accompanying handouts.

II. What groups are meant to be protected by this law?

The "vulnerable," who are adults unable to protect themselves from abuse, neglect, exploitation or endangerment because of mental or physical impairments or because of the frailties or dependencies of advanced age. (Sec 11).

The use of the term "vulnerable" as a trigger for government intervention seems unique to APS law, and has not been subject to court interpretation yet. This standard is defined, and determined, in very different ways than are the standards used by probate courts in determining capacity or competency in guardianship and conservatorship hearings, or the standards used by trial courts in determining "informed consent" for medical procedures. A determination that a person is or is not "vulnerable" is inconclusive as to whether he or she is capable of making other decisions.

III. Who must report "abuse," and what is the standard for reporting it?

Physicians who "suspect" or have "reasonable cause to believe" that abuse has occurred must make a report, as must persons who are employed, licensed, registered, or certified to provide health care, education, social welfare, mental health, or other human services work; employees of such agencies; police; and employees of the offices of the county medical examiner (Sec 11a (1)). Anyone else who suspects abuse has occurred may report it as well (Sec 11a (2)).

This section of the law contains two discrete reporting standards. The first, that abuse be reported when it is "suspected," is a personal and subjective test, dependent upon the onlooker's intelligence and powers of observation. The second, that abuse be reported if the onlooker has "reasonable cause to believe" it has or is occurring, is a communal and objective standard, dependent presumably upon whether others of similar backgrounds and in similar

circumstances would reasonably conclude that abuse was occurring and report it. It is likely this second standard is intended to be used as the basis of deciding whether sanctions for the failure to report abuse should be invoked, as discussed below.

IV. What are the sanctions for failing to report "abuse?"

The APS law provides that a person who is mandated to report abuse and who fails to do so may be subject to a $500 civil fine or to civil liability for any later damages (Sec 11e). Additionally, in theory, the failure to comply with a legal duty, such as a duty to report abuse under an APS law, may be the basis for bringing either criminal prosecution or professional delicensure or related sanctions.

To date, there seems to have been no cases reported in which sanctions for failure to report abuse were sought or upheld under APS statutes. However, there have been civil and licensure sanctions sought and upheld for the failure to report abuse or neglect under CHILD protective services or other laws.

V. What are the safeguards provided to those who do report "abuse?"

The reporter's identity will be kept in confidence, unless ordered disclosed by a court (Sec 11c), meaning neither the victim nor the purported abuser need necessarily know who reported the case to the APS program. The reporter is additionally given immunity from civil liability for making a report of abuse "in good faith," and the APS law presumes all reports are made "in good faith (Sec 11c).

To date, there seems to have been no cases reported in which a reporter's immunity for making a report under an APS statute has been challenged. There is one CHILD protective services case in which a physician was sued for making what turned out to be an unfounded report of child abuse. The court ruled the physician was not liable for making the incorrect report, based on the act's absolute immunity clause.

VI. How is a report made?

A report must be made "immediately" to the local county office of the Department of Social Services. It may be made by telephone, or in person. It seemingly must include the adult's name, and a description of the abuse. It should include the adult's age, names and addresses of family and other caretakers, as well as any information which may help establish the cause of the abuse (Sec 11 (a)(4)).

VII. What can APS do to remedy abuse?

The APS worker, if he or she determines that the individual is vulnerable and "in need of protective services," can provide remedial, social, legal, health, mental health and referral services (Sec 11). The worker may refer the case to the police (Sec 11a (5)). The enclosed handouts contain further information about possible remedies. (continued next page)

Additionally, legal intervention may prevent or stop abuse. For physical abuse, in appropriate cases, an injunction may be issued by a court preventing the abuser from harassing, assaulting, or entering the premises of the victim. Violation of the injunction may result in immediate arrest and detention. Evictions may be sought to eject a non-violent abuser from the home of his or her victim.

For financial abuse, or "exploitation", legal intervention may limit further abuse and seek to recover that which has already been taken, by removing assets from the control of the abuser and by bringing actions to either reconvey property taken which can be returned, or to seek money damages for that which cannot.

VII. Are there other laws that require physicians to report "abuse?"

The APS law is one of several laws requiring physicians to report abuse. Physicians have long known they must report child abuse. Additionally, Michigan's public health code, with its general patient rights provisions, and the nursing home code, with its more specific provisions regarding nursing home residents, also require physicians to report abuse in licensed health care facilities. The mental health code requires persons who work for the department, or for an agency which contracts with the department to report abuse of residents or recipients of mental health services.

VIII. Procedural questions

Q. I saw an abuse victim today, but someone else said he was going to report it to APS. Do I still have to file a report?

A. Yes. The Michigan APS law, as yet uninterpreted by the courts, requires you to report suspected abuse, regardless of what others may do.

Q. My hospital administrator says that all proposed abuse reports must come to her office, and that she will decide whether they are to be sent on to APS. If I do this, does it fulfill my obligation to report?

A. No, although a proper review which might help clarify a situation would seem appropriate, providing the victim is not left unprotected in the meantime.

SUBSTITUTED DECISION MAKING

Some people cannot make meaningful personal or financial decisions for themselves, so that others must make decisions for them. The authority by which these helpers, or "substituted decision makers," act may come through the use of voluntary or involuntary legal arrangements.

I. VOLUNTARY TRANSFERS OF DECISION MAKING

A person presently able to make his or her own decisions may voluntarily share his or her right of financial and personal decision-making with someone else.

JOINT PROPERTY OWNERSHIP

The most widely used means of sharing financial decision making are joint property ownership agreements. The owner of a bank account, real estate, stock, or similar asset can give part ownership of the asset to another, allowing either owner to manage it. These arrangements may also avoid the need to probate the asset after the death of its original owner. However, these relationships may present problems with income tax, government benefits eligibility, and with misuse of the property by the new owner.

POWER OF ATTORNEY

A Power of Attorney may be used to transfer financial and sometimes personal decision making. It is basically a letter in which one person, called the "maker" or "principal", gives another person, called the "attorney in fact" or "agent", the legal authority to act on the "maker's" behalf. The maker can giver either broad or narrow authority to the agent, as he or she thinks best.

Powers of Attorney usually take effect when signed. They remain in effect until their makers revoke them, or, for Powers of Attorney that note they are "durable," until the death of their makers. Powers of Attorney which do NOT include a "durable" provision only remain in effect for as long as their makers are mentally alert.

An agent's authority and responsibility under a Power of Attorney is to act solely on the maker's behalf. The Power of Attorney does not give the agent any personal right to the money or property covered under the letter, nor can the agent's creditors make any claim to it. However, there is no clear legal requirement that third parties such as banks, stock companies, or doctors honor them nor is there any immediate court protection should the agent misuse his or her authority.

II. INVOLUNTARY TRANSFERS OF DECISION MAKING

If an individual can no longer make decisions, and no adequate voluntary arrangements exist, the Probate Court can transfer the impaired person's decision making authority to another.

GUARDIANSHIP

If an individual can no longer decide personal matters, such as where he or she will live or whether to have medical treatment or not, the court proceeding is called "guardianship". A paper, or "petition," is filed in the local probate court, stating why the guardianship is needed and whom the members of the impaired person's family are who ought to be notified of the hearing. The court appoints a "Guardian ad Litem" to interview the impaired person and the petitioner, and then holds a hearing at which a decision is made as to whether the impaired person is truly incapable of managing his or her affairs and whether someone else should be appointed his or her guardian.

Traditionally, the guardian's authority to make decisions for the impaired person (called the "ward") is usually absolute, although there is a new law which allows partial or limited guardians to be appointed. Unlike a Power of Attorney, a bank or doctor cannot refuse to honor the guardian's decisions, since the guardian can return to the court and get an order directing them to accept his or her decisions.

The guardian's power, however, comes at the expense of the ward. Once a guardian is appointed, the ward generally loses all his or her rights to make personal decisions, including the right to decide where to live, who or whether to marry or divorce, or what sort of medical treatment to receive.

CONSERVATOR

If the individual can no longer make financial decisions, such as paying utilities or rent, collecting income, or protecting assets, the local probate court may appoint a "conservator." The court process is very similar to that of guardianship, and it is common for an impaired person to have a combined guardianship/conservatorship hearing.

The conservator's authority to make FINANCIAL decisions for the impaired person is usually absolute, and come at the expense of the impaired person. However, a conservator has no legal right to make PERSONAL decisions, such as medical treatment choices, for the impaired person. These rights belongs to the guardian, if one is appointed, or to the individual if no guardian is appointed.

ELDER ABUSE
Effective Management: Assessment & Resources

Leon Schrauben, MSW,ACSW
Sue Haviland, RN,MSN

I. Overview

A. Outcomes of assessment: two possible situations

1. Potential

2. Actual

B. Settings in which abuse occurs

C. Family/caregiver dynamics

1. Matrix of management plan

2. Family/caregiver strengths

3. Stressors/precipitants of abuse

D. General approaches to intervention & management

1. Professional relationship & importance of referral

2. Things to avoid

3. Goals of management plan

II. Management & Follow-Up

A. General principles

1. Physician's role

2. Collaboration

3. Role of other professionals
   a. nurse
   b. social worker
   c. others - dietician, PT, dentist

4. Need for case management

5. Impaired vs. unimpaired victim

6. Intentionally vs. unintentionally of abuser

7. Documentation

B. Adult Protective Services role

C. Short-term management

1. Report to APS

2. Assessment of imminent harm - physical safety of victim

3. Protection of victim - removal of victim vs. abuser
   a. removal of victim from situation

      1) Hospitalization
         Treatment of injury
         DRG 454, 455
            - co-morbidity, basis for justification
            - utilization review issues

      2) Emergency placement - DSS

   b. Removal of abuser
   c. In-home protection/assistance

4. Caregiver interventions

5. Legal action as needed

D. Long-term management

III. Case examples

IV. Video tape

SETTINGS IN WHICH ABUSE OCCURS

REPORTING PROTOCOL

I. Institutional setting

A. Nursing home

1. Michigan Department of Public Health - Licensing and Regulation

2. Nursing supervisor

3. Administrator

B. Adult Foster Care Home

1. Adult Protective Services

C. Hospital

1. Nursing supervisor

2. Administrator

II. Home/Community

1. Adult Protective Services

FAMILY/CAREGIVER DYNAMICS

STRENGTHS

A. Recognition, acceptance of the patient's situation

1. cognitive status
2. functional status

B. Adapting to change

1. in roles
2. in life style

C. Communication

1. in family and social system
2. with health and human service providers
3. between caregivers and patient

D. Family and social support

1. family harmony, agreement
2. support in caregiving
   a. emotional
   b. direct care
   c. financial
3. acceptance, agreement on family member responsibilities

E. Financial resources

1. patient and caregiver able to meet their present needs
2. confident about meeting anticipated needs
3. appropriate management of finances

F. Coping with feelings

1. understanding patient's feelings, behavior
2. acceptance of personal feelings regarding caregiving, dependency and role changes
3. acceptance of family member's feelings

G. Successful coping may include

1. seeking information
2. sharing concerns, talking to others
3. diverting attention, attending to personal needs
4. talking action based on understanding
5. confidence in problem solving

FAMILY/CAREGIVER DYNAMICS

STRESSORS/PRECIPITANTS OF ABUSE/NEGLECT

A. Family dynamics

1. poor past relationships
2. history of family and marital conflict
3. history of abuse and neglect/family violence

B. Impairment and dependence of patient

1. cognitive impairment
2. functional limitations
3. psychiatric problems

C. Psychopathology of caregiver

1. history of mental illness or current psychological problems
2. cognitive impairment
3. alcohol and drug abuse

D. Difficult behaviors of patient

1. combativeness
2. incontinence
3. wandering, etc.

E. Internal stress, feelings of being:

1. overwhelmed with responsibility
2. unappreciated
3. inadequate as a caregiver

F. External stressors

1. difficulty meeting existing responsibilities
2. family, friends
3. job responsibilities
4. recent or recurrent problems
5. loss of job
6. change in health
7. relocation

GENERAL APPROACH TO INTERVENTION/COMMUNICATION WITH VICTIM AND ABUSER

AVOID:

1. Blaming the victim
   - "Why didn't you do something?"
2. Blaming the alleged/identified abuser
   - alienates person; destroys trust
3. Confrontation
4. Threats, punitive measures
5. Projecting biases
   - "abusers should be imprisoned"
6. Over reacting to situation
   - removing patient from the home when home care interventions are indicated
7. Acting in isolation
   - over involvement

RIGHTS

- INDIVIDUALS HAVE THE RIGHT TO ACCEPT, OR REFUSE SERVICES OFFERED BY THE DEPARTMENT OF SOCIAL SERVICES, AND THESE RIGHTS WILL BE UPHELD AS LONG AS THE INDIVIDUAL IS COMPETENT TO MAKE DECISIONS.

- INDIVIDUALS HAVE THE RIGHT TO MAKE DECISIONS, OR LIVE LIFE-STYLES THAT MAY BE DIFFERENT FROM WHAT SERVICES WORKERS, OR THE COMMUNITY AT LARGE, MIGHT APPROVE OF OR CHOOSE FOR THEMSELVES.

- EVERYONE IS CONSIDERED COMPETENT UNTIL THE COURTS -- NOT THE DEPARTMENT OF SOCIAL SERVICES -- DETERMINES OTHERWISE.

- ANY PERSON MAKING A REFERRAL TO THE DEPARTMENT OF SOCIAL SERVICES HAS THE RIGHT TO REMAIN ANONYMOUS, OR REQUEST THAT THEIR NAME REMAIN CONFIDENTIAL, NOT RELEASED TO ANYONE.

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*Summary of Major Principles

I. The Social Worker's Conduct and Comportment as a Social Worker

A. *Propriety.*
The social worker should maintain high standards of personal conduct in the capacity or identity as social worker.

B. *Competence and Professional Development.*
The social worker should strive to become and remain proficient in professional practice and the performance of professional functions.

C. *Service.*
The social worker should regard as primary the service obligation of the social work profession.

D. *Integrity.*
The social worker should act in accordance with the highest standards of professional integrity.

E. *Scholarship and Research.*
The social worker engaged in study and research should be guided by the conventions of scholarly inquiry.

II. The Social Worker's Ethical Responsibility to Clients

F. *Primacy of Clients' Interests.*
The social worker's primary responsibility is to clients.

G. *Rights and Prerogatives of Clients.*
The social worker should make every effort to foster maximum self-determination on the part of clients.

H. *Confidentiality and Privacy.*
The social worker should respect the privacy of clients and hold in confidence all information obtained in the course of professional service.

I. *Fees.*
When setting fees, the social worker should ensure that they are fair, reasonable, considerate, and commensurate with the service performed and with due regard for the clients' ability to pay.

III. The Social Worker's Ethical Responsibility to Colleagues

J. *Respect, Fairness, and Courtesy.*
The social worker should treat colleagues with respect, courtesy, fairness, and good faith.

K. *Dealing with Colleagues' Clients.*
The social worker has the responsibility to relate to the clients of colleagues with full professional consideration.

IV. The Social Worker's Ethical Responsibility to Employers and Employing Organizations

L. *Commitments to Employing Organizations.*
The social worker should adhere to commitments made to the employing organizations.

V. The Social Worker's Ethical Responsibility to the Social Work Profession

M. *Maintaining the Integrity of the Profession*
The social worker should uphold and advance the values, ethics, knowledge, and mission of the profession.

N. *Community Service.*
The social worker should assist the profession in making social services available to the general public.

O. *Development of Knowledge.*
The social worker should take responsibility for identifying, developing, and fully utilizing knowledge for professional practice.

VI. The Social Worker's Ethical Responsibility to Society

P. *Promoting the General Welfare.*
The social worker should promote the general welfare of society.

*The above constitutes a summary of the Code of Ethics effective July 1, 1980, as adopted by the 1979 NASW Delegate Assembly. The complete text, including preamble and expanded definition of principles, is available upon request.

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PROGRAM OVERVIEW

MISSION STATEMENT

Adult Services seeks to maximize the independent functioning of adults and the independent control of adults over their own lives; to protect vulnerable adults from abuse, neglect, exploitation and endangerment; and to advocate for the aged and disabled.

PRINCIPLES

In carrying out this mission, certain operating principles are to be considered. These are:

- Adults have a right to make their own decisions. This includes:
  - decisions as to whether they want service, what services or how much and from whom
  - decisions as to where they live
  - being involved in the service planning
- Services must recognize the role of the family. Family involvement should be supported by:
  - seeking out the family
  - involving them in service planning
  - directing services and resources toward the family in their role as caregiver

  If the interest of the family and the adult compete, the adult's interest is primary.
- Services should be the least intrusive, least disruptive and least restrictive.
- Services should be part of a coordinated network of community-based services, using all appropriate existing community services and identifying the need for an developing additional services.
- In providing services to adults, the full range of social work skills should be used to inform clients of services and alternatives available and the impact of decisions to assure informed choices.

The Principles of Adult Protection

- When interests compete, the adult client is the only person you are charged to serve; not the community concerned about safety, the landlords concerned about property, citizens concerned about crime or morality, families concerned about their own health or finances.
- When interests compete, the adult client is in charge of decision-making until she/he delegates responsibility voluntarily to another or the court grants responsibility to another.
- A person can choose to live in harm or even self-destructively provided she/he is competent to choose, does not harm others and commits no crimes. Freedom is more important than safety.
- In serving the adult client, the full range of social work skills must be used to assure the client is fully aware of alternatives, and can make an informed choice.
- Protection of adults seeks to achieve simultaneously and in order of importance: freedom, safety, least disruption of life-style and least restrictive care alternative.

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CLOSING SUMMARY RECORD

Michigan Department of Social Services
ADULT PROTECTIVE SERVICES

See Reverse Side for Instructions

COMPLAINT NUMBER

Appendix C: Item 6: ___

Case Mgmt: APS Materials

1. CASE NUMBER	2. OCCURRENCE NUMBER
CASE NAME	26. DATE OF CLOSURE

27. CLOSURE CODE
- ☐ 1. Unsubstantiated
- ☐ 2. Unsubstantiated, transferred to another program
- ☐ 3. Substantiated, adult refused services
- ☐ 4. Substantiated, adult living in safe, stable situation
- ☐ 5. Substantiated, adult moved out of county
- ☐ 6. Substantiated, adult deceased
- ☐ 7. Substantiated, transferred to another program

28. RESOURCES GIVEN
- ☐ 1. None
- ☐ 2. Adult Day Care
- ☐ 3. Legal Intervention
- ☐ 4. Family Assistance
- ☐ 5. AFC/NH/HA Placement
- ☐ 6. Financial
- ☐ 7. Health
- ☐ 8. Home Help
- ☐ 9. Mental Health
- ☐ 10. Shelter
- ☐ 11. Other _____
- ☐ 12. DSS Counseling

29. RESOURCES NOT AVAILABLE
- ☐ 1. Not Applicable
- ☐ 2. Adult Day Care
- ☐ 3. Legal Intervention
- ☐ 4. Family Assistance
- ☐ 5. AFC/NH/HA Placement
- ☐ 6. Financial
- ☐ 7. Health
- ☐ 8. Home Help
- ☐ 9. Mental Health
- ☐ 10. Shelter
- ☐ 11. Other _____

30. CLOSING LIVING ARRANGEMENT
- ☐ 1. Alone
- ☐ 3. Spouse
- ☐ 4. Relative
- ☐ 5. Other Person
- ☐ 9. AFC/HA
- ☐ 10. Nursing Home
- ☐ 12. Homeless
- ☐ 13. Other Group

31. LEGAL INTERVENTION
- ☐ 1. None
- ☐ 2. Unsuccessful action
- ☐ 3. Arrange for power of attorney
- ☐ 4. Arrange for representative payee
- ☐ 5. Appointment of guardian
- ☐ 6. Appointment of conservator
- ☐ 7. Appointment of both guardian and conservator
- ☐ 8. Appointment of temporary guardian
- ☐ 9. Appointment of partial guardian or conservator
- ☐ 10. Civil commitment
- ☐ 11. Removal of guardian or conservator
- ☐ 12. Removal of guardian or conservator, appointment of new guardian or conservator

32. CLOSING LEGAL STATUS
- ☐ 1. No Legal Restrictions
- ☐ 2. Power of Attorney
- ☐ 3. Representative Payee
- ☐ 4. Guardian
- ☐ 5. Conservator
- ☐ 6. Temporary Guardian
- ☐ 7. Partial Guardian
- ☐ 8. Civil Commitment

33. INITIATOR/PETITIONER
- ☐ 1. DSS
- ☐ 2. Family Member
- ☐ 3. Client
- ☐ 4. Other
- ☐ 5. N.A.

34. APPOINTED/RESPONSIBLE PERSON
- ☐ 1. Relative
- ☐ 2. Friend
- ☐ 3. Public Agency
- ☐ 4. Private Agency
- ☐ 5. Volunteer
- ☐ 6. N.A.

35. CRIMINAL INVESTIGATION REFERRAL

☐ 1. Yes ☐ 2. No

Worker Signature
Load No.

DSS-3922 (Rev. 11-88) Previous edition obsolete.

DISTRIBUTION: PART 1 - Case Record
PART 2 - APS Complaint Coordinator
PART 3 - APS/LOA System Coordinator

ADULT PROTECTIVE SERVICES REFERRAL REPORT

Michigan Department of Social Services

See reverse side for instructions and copy distribution.

Date of Referral | Time : ☐ AM ☐ PM | County | District

Method of Referral: ☐ Phone ☐ Letter ☐ In Person ☐ DSS Worker ☐ Other

Recording Person's Name | Complaint Number

1. Case Number | 2. Occur. | 3. After-hour Referrals ☐ YES ☐ NO

A. - REFERRAL INFORMATION:

4. CLIENT'S NAME (Last, First, Middle) | 5. Birth Date | 6. Sex ☐ Male ☐ Female | 7. Phone Number

8. Address (Street Number and Name) | Social Security Number

9. City | 10. State | 11. Zip Code | 12. Opening Financial Status ☐ 1. DSS Payment Program ☐ 2. Low Income ☐ 3. Adequate Resources

13. Race Code ☐ 1. White ☐ 2. Black ☐ 3. Am. Indian ☐ 4. Other ☐ 5. Unknown ☐ 6. Hispanic

14. Living Arrangement ☐ 1. Alone ☐ 3. Spouse ☐ 4. Relative ☐ 5. Other Person ☐ 9. AFC/HA ☐ 10. Nursing Home ☐ 12. Homeless ☐ 13. Other Group

15. Marital Status ☐ 1. Single ☐ 2. Married ☐ 3. Divorced ☐ 4. Widowed

16. Opening Legal Status ☐ 1. No Legal Restrictions ☐ 2. Power of Attorney ☐ 3. Representative Payee ☐ 4. Guardian ☐ 5. Conservator ☐ 6. Temporary Guardian ☐ 7. Partial Guardian ☐ 8. Civil Commitment

REFERRAL SOURCE Name (Last, First, Middle) | Phone Number

Address (Street Number and Name)

City | State | Zip Code

17. Referral Source ☐ 1. Health Care Provider ☐ 2. Educator ☐ 3. Social Welfare Prov. ☐ 4. Mental Health ☐ 5. Law Enforcement ☐ 6. County Med. Examiner ☐ 7. Physician ☐ 8. Client ☐ 9. Friend ☐ 10. Relative ☐ 11. Concerned Citizen

ALLEGED PERPETRATOR Name (Last, First, Middle)

Address (Street Number and Name)

City | State | Zip Code

18. Alleged Perpetrator ☐ 1. Self ☐ 2. Spouse ☐ 3. Child (Son/Daughter) ☐ 4. Other Relative ☐ 5. Unrelated Caregiver ☐ 6. Other

Phone Number | Live With Client? ☐ YES ☐ NO | Primary Caregiver ☐ YES ☐ NO

REFERRAL NARRATIVE (ATTACH ADDITIONAL NARRATIVE AS NEEDED)

B. - SUPERVISOR REVIEW (Complaint Coordinator)

Review Date | Time : ☐ AM ☐ PM | Date Service Plan Due | Assigned for Investigation ☐ NO ☐ YES ▶ Assigned To

19. Worker Load Number | Referred To ☐ DMH ☐ DPH ☐ AG | Supervisor/Complaint Coordinator Signature | Date

C. - CASE DISPOSITION SUMMARY

20. Substantiated Referral? ☐ NO ☐ YES

21. Harm Type ☐ 1. Abuse ☐ 2. Neglect ☐ 3. Exploitation ☐ 4. Endangerment

22. Vulnerability ☐ 1. Physical Impairment ☐ 2. Mental Impair. /DD ☐ 3. Mental Impair./Mental Illness ☐ 4. Frailties or Depends. Advanced Age

23. Opening Date | First Contact Date | Time : ☐ AM ☐ PM | Workers Signature | Date

24. 24-Hour Response ☐ YES ☐ NO

25. 14-Day Service Plan ☐ YES ☐ NO ☐ U

DSS-242 (Rev. 2-89) Previous edition obsolete. Also obsoletes DSS-242A

ST. LAWRENCE/MSU GERIATRIC ASSESSMENT CENTER

Name Mrs. B.

D.O.B. 03/06/03 (83) Sex F

Education High School

Income (yearly) X 20,000 or more 10,000 - 19,999 5,000 - 9,999 Under 5,000

Living Arrangements:

Place: Own Home X Apartment ____ AFC ____ Other ____

Lives With: Alone ____ Spouse X Other ____

Medical Problems		Psycho-Social, Family, Legal, Economic Problems	
1. Cognitive impairment	6.	1. Social isolation	
2. Akathesia/Chorea	7.	2. Caregiver stress	
3. Keratoderma	8.	3. Husband/caregiver depressed	
4. Cataracts bilateral	9.	4. Neglect: Physical Psychological Financial	
5.	10.	5.	

Medications		GDS Score 4 MMSE					
1. Mellaril 10 mg. daily	6.	Date:	06/87	05/88			
2.	7.	Orient Time (5)	3	4			
3.	8.	Orient Place (5)	3	3			
4.	9.	Registration (3)	3	3			
5.	10.	Attn/Calculation (5)	3	4			
		Recall (3)	0	1			
		Language (9)	8	6			
		TOTAL	20	21			

IADL Date	06/87		05/88			
	I	D	I	D	I	D
Phone		X		X		
Transportation		X		X		
Shopping		X		X		
Housework		X		X		
Cooking		X		X		
Medications		X		X		
Handling $		X		X		
TOTAL	0	7	0	7		

ADL Date	06/87		05/88			
	I	D	I	D	I	D
Bathing	X			X		
Dressing	X			X		
Toileting	X		X			
Transfer	X		X			
Continence	X		X			
Walking	X		X			
Eating/Feeding	X		X			
TOTAL	7	0	5	2		

GDS GERIATRIC DEPRESSION SCALE
MMSE MINI-MENTAL STATE EXAM
ADL ACTIVITIES OF DAILY LIVING
IADL INSTRUMENTAL ACTIVITIES OF DAILY LIVING

ST. LAWRENCE/MSU GERIATRIC ASSESSMENT CENTER

Appendix C: Item 6: Case Mgmt: Case Histories

Name Mrs. G.

D.O.B. 05/08/07 (82) Sex F

Education High School

Income (yearly) X 20,000 or more; 10,000 - 19,999; 5,000 - 9,999; Under 5,000

Living Arrangements:

Place: Own Home X; Apartment ____; AFC ____; Other ____

Lives With: Alone X; Spouse ____; Other ____

Medical Problems		Psycho-Social, Family, Legal, Economic Problems	
1. Cognitive impairment	6.	1. Social isolation	
2. Visual impairment	7.	2. Family discord	
3. Hearing impairment	8.	3. Neglect: Physical	
4.	9.	4.	Psychological
5.	10.	5.	Financial

Medications

1. None
2.
3.
4.
5.
6.
7.
8.
9.
10.

GDS Score NA

MMSE

Date:	12/87	04/88			
Orient Time (5)	0	0			
Orient Place (5)	0	0			
Registration (3)	3	0			
Attn/Calculation (5)	0	0			
Recall (3)	0	0			
Language (9)	0	0			
TOTAL	3	0			

IADL

Date	12/87		04/88			
	I	D	I	D	I	D
Phone		X		X		
Transportation		X		X		
Shopping		X		X		
Housework		X		X		
Cooking		X		X		
Medications		X		X		
Handling $		X		X		
TOTAL	0	7	0	7		

ADL

Date	12/87		04/88			
	I	D	I	D	I	D
Bathing		X		X		
Dressing		X		X		
Toileting		X		X		
Transfer	X			X		
Continence		X		X		
Walking	X			X		
Eating/Feeding	X		X			
TOTAL	3	4	1	6		

GDS GERIATRIC DEPRESSION SCALE
MMSE MINI-MENTAL STATE EXAM
ADL ACTIVITIES OF DAILY LIVING
IADL INSTRUMENTAL ACTIVITIES OF DAILY LIVING

ST. LAWRENCE/MSU GERIATRIC ASSESSMENT CENTER

Name Mr. I.

D.O.B. 04/13/18 (71) Sex M

Education High School

Income (yearly) 20,000 or more X 5,000 - 9,999 10,000 - 19,999 Under 5,000

Living Arrangements:

Place: Own Home ____ AFC ____ Apartment ____ Other X

Lives With: Alone ____ Spouse ____ Other Sister-in-law

Medical Problems		Psycho-Social, Family, Legal, Economic Problems
1. Post-polio syndrome	6. DJD	1. Social isolation
2. Status post polio	7. PVD	2. Caregiver stress
3. Impaired mobility secondary to #1&#2	8. Cataracts-bilateral	3. Physical neglect
4. Kyphoscoliosis	9. Hypertension	4. Psychological neglect/abu
5.	10.	5.

Medications		GDS Score 7 MMSE						
1. Zantac 150 mg. bid	6.	Date:		12/88				
2. Corgard 40 mg. daily	7.	Orient Time	(5)	4				
3. Trimethoprim 100 mg. bid	8.	Orient Place	(5)	5				
4.	9.	Registration	(3)	3				
5.	10.	Attn/Calculation	(5)	4				
		Recall	(3)	2				
		Language	(9)	6/6				
		TOTAL		24/27				

IADL Date	02/88						ADL Date	02/88					
	I	D	I	D	I	D		I	D	I	D	I	D
Phone	X						Bathing		X				
Transportation		X					Dressing		X				
Shopping		X					Toileting		X				
Housework		X					Transfer		X				
Cooking		X					Continence	X					
Medications	X						Walking		X				
Handling $	X						Eating/Feeding	X					
TOTAL	3	4					TOTAL	2	5				

GDS GERIATRIC DEPRESSION SCALE
MMSE MINI-MENTAL STATE EXAM
ADL ACTIVITIES OF DAILY LIVING
IADL INSTRUMENTAL ACTIVITIES OF DAILY LIVING

CASE ILLUSTRATIONS

1. Mrs. B.

Mrs. B., age 83, has had a several year history of increasing cognitive impairment. Her husband, age 84, has been described by neighbors and friends (there are no children or close relatives) as being responsible and sensitive to her needs in the past. Mr. B. has become severely depressed over the last year with associated cognitive impairment. He is unable to identify his needs or his wife's needs. The couple is socially isolated due to Mr. B's. hostility and refusal to accept help. Mr. B. does not provide for adequate nutrition and supervision for his wife. He refuses to pay for services in the home.

2. Mrs. G.

Mrs. G., is an 82 year old woman living alone. Socially isolated, her only visitors are a niece and a friend from church. This friend is a member of the advisory board of the local area agency on aging and has been Mrs. G's. conservator for two years. Mrs. G's. niece is concerned about her aunt,s living conditions which are described as unsafe and unclean. The patient's niece reports many items missing from her aunt's home, including family heirlooms and furs, and is concerned about her aunt's finances. The conservator reports that Mrs. G. has no savings and is unable to pay for services. The patients' niece believes her aunt had at least least $30,000.00 two years ago.

3. Mr. L.

Mr. L., is a 71 year old widowed male with a history of polio and post polio syndrome. He has paralysis in his right arm and left leg with weakness in his left arm and right leg. He wears a body brace and two leg braces. He needs two people to assist in transfer. Mr. L. has lived his adult life in a small home he built behind his brothers house. Mr. L. is widowed and his brother is now deceased. Mr. L's. sister-in-law has cared for him for many years. She is 70 years old, unable to lift and transfer him and is extremely stressed with his care needs. Mr. L. is left unattended in bed for long periods of time. His sister-in-law frequently berates him in front of others, referring to him as "dead meat." Mr. L. is dependent on his sister-in-law for care and is reluctant to criticize her.

MEDICALLY-RELATED ARTICLES ON ELDER ABUSE

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APPENDIX D:

Evaluation Materials

Item 1: Evaluation Questionnaire

Item 2: Program Evaluation Results: June 21, 1989

Item 3: Program Evaluation Results: August 11, 1989

Item 4: Program Evaluation Results: September 9, 1989

Item 5: Program Evaluation Results: September 21, 1989

Item 6: Program Evaluation Results: November 29, 1989

• SHORT TERM TRAINING ON ELDER ABUSE FOR PHYSICIANS
PROGRAM EVALUATION FORM

DATE OF PROGRAM: _____

Where did you hear about this training program?

☐ Brochure ☐ Another physician

☐ Through hospital ☐ Another health care professional

☐ Medical journal ☐ Other media (Specify)_____

☐ Other (Specify): _____

Please take a few minutes to complete the following evaluation.
(CIRCLE THE APPROPRIATE VALUE FOR EACH ITEM)

	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
OVERALL THE SESSION WAS:	1	2	3	4	5
INTRODUCTORY LECTURE WAS:	1	2	3	4	5
INTRODUCTORY SLIDES WERE:	1	2	3	4	5
CLINICAL DIAGNOSIS LECTURE WAS:	1	2	3	4	5
CLINICAL DIAGNOSIS VIDEOTAPE WAS:	1	2	3	4	5
CLINICAL DIAGNOSIS SLIDES WERE:	1	2	3	4	5
LEGAL ISSUES LECTURE WAS:	1	2	3	4	5
LEGAL ISSUES VIDEOTAPE WAS:	1	2	3	4	5
CASE MANAGEMENT LECTURE WAS:	1	2	3	4	5
CASE MANAGEMENT VIDEOTAPE WAS:	1	2	3	4	5
QUESTION AND ANSWER SESSION WAS:	1	2	3	4	5

To what extent will your practice change because of what you learned today?

NOT AT ALL	1	2	3	4	5	VERY MUCH

How will your practice change as a result of what you learned today?

_____

What information do you feel you did not get in this session?

_____

PLEASE ADD ANY OTHER COMMENTS ON THE BACK OF THIS FORM. THANK YOU.

SPEC/WSUEA **6-6-89**

SHORT-TERM TRAINING ON ELDER ABUSE FOR PHYSICIANS

PROGRAM EVALUATION RESULTS

JUNE 21, 1989

SPEC ASSOCIATES

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SHORT TERM TRAINING ON ELDER ABUSE FOR PHYSICIANS

PROGRAM EVALUATION RESULTS

SESSION DATE: JUNE 21, 1989

EVALUATION TOPIC:	FREQUENCY OF RESPONSES: POOR 1	FAIR 2	GOOD 3	VERY GOOD 4	EXCELLENT 5	NO RESPONSE -9	AVERAGE SCORE SCALE OF 1 TO 5
OVERALL, THE SESSION WAS:	0	0	0	1	3	0	4.75
INTRODUCTORY LECTURE WAS:	0	0	0	2	2	0	4.50
INTRODUCTORY SLIDES WERE:	0	0	1	1	2	0	4.25
CLINICAL DIAGNOSIS LECTURE WAS:	0	0	0	2	2	0	4.50
CLINICAL DIAGNOSIS VIDEOTAPE WAS:	0	0	0	2	2	0	4.50
CLINICAL DIAGNOSIS SLIDES WERE:	0	0	0	2	2	0	4.50
LEGAL ISSUES LECTURE WAS:	0	0	0	1	3	0	4.75
LEGAL ISSUES VIDEOTAPE WAS:	0	0	2	0	2	0	4.00
CASE MANAGEMENT LECTURE WAS:	0	0	0	2	2	0	4.50
CASE MANAGEMENT VIDEOTAPE WAS:	0	0	0	1	3	0	4.75
QUESTION AND ANSWER SESSION WAS:	0	0	1	0	3	0	4.50

To what extent will your practice change because of what you learned today?

	1	2	3	4	5	
NOT AT ALL	0	0	0	2	2	VERY MUCH
	0%	0%	0%	50%	50%	

Where did you hear about this training program?

	FREQ.	PCT.
BROCHURE	2	50%
THROUGH HOSPITAL	1	25%
MEDICAL JOURNAL	0	0%
ANOTHER PHYSICIAN	1	25%
ANOTHER HEALTH CARE PROFESSIONAL	0	0%
OTHER MEDIA	0	0%
OTHER	0	0%

SHORT-TERM TRAINING ON ELDER ABUSE FOR PHYSICIANS
PROGRAM EVALUATION FORM

DATE OF TRAINING: JUNE 21, 1989

ANSWERS TO OPEN-ENDED EVALUATION QUESTIONS

How will your practice change as a result of what you learned today?

With more knowledge, sensitivity and awareness.

More awareness of elder abuse in general, and keeping an eye out for it. Also, how to refer these patients if you suspect a problem.

Better able to identify and report elder abuse.

Excellent - this is a topic that is not taught to us during residency.

What information do you feel you did not get in this session?

I would appreciate more real case scenarios.

Everything seemed to be covered.

SHORT-TERM TRAINING ON ELDER ABUSE FOR PHYSICIANS

PROGRAM EVALUATION RESULTS

AUGUST 11, 1989

SHORT TERM TRAINING ON ELDER ABUSE FOR PHYSICIANS

PROGRAM EVALUATION RESULTS

SESSION DATE: AUGUST 11, 1989

EVALUATION TOPIC:	FREQUENCY OF RESPONSES: POOR 1	FAIR 2	GOOD 3	VERY GOOD 4	EXCELLENT 5	NO RESPONSE -9	AVERAGE SCORE SCALE OF 1 TO 5
OVERALL, THE SESSION WAS:	0	0	1	7	0	0	3.88
INTRODUCTORY LECTURE WAS:	0	0	3	4	1	0	3.75
INTRODUCTORY SLIDES WERE:	0	0	4	3	1	0	3.63
CLINICAL DIAGNOSIS LECTURE WAS:	0	0	1	7	0	0	3.88
CLINICAL DIAGNOSIS VIDEOTAPE WAS:	0	0	3	5	0	0	3.63
CLINICAL DIAGNOSIS SLIDES WERE:	0	0	1	7	0	0	3.88
LEGAL ISSUES LECTURE WAS:	0	0	0	4	4	0	4.50
LEGAL ISSUES VIDEOTAPE WAS:	0	0	0	7	1	0	4.13
CASE MANAGEMENT LECTURE WAS:	0	0	3	4	0	1	3.57
CASE MANAGEMENT VIDEOTAPE WAS:	0	0	2	2	3	1	4.14
QUESTION AND ANSWER SESSION WAS:	0	1	2	4	0	1	3.43

To what extent will your practice change because of what you learned today?

	1	2	3	4	5	
NOT AT ALL	0	0	1	5	1	VERY MUCH
	0%	0%	14%	71%	14%	

Where did you hear about this training program?

	FREQ.	PCT.
BROCHURE	4	50%
THROUGH HOSPITAL	1	13%
MEDICAL JOURNAL	0	0%
ANOTHER PHYSICIAN	1	13%
ANOTHER HEALTH CARE PROFESSIONAL	1	13%
OTHER MEDIA	0	0%
OTHER	1	13%

SHORT-TERM TRAINING ON ELDER ABUSE FOR PHYSICIANS
PROGRAM EVALUATION FORM

DATE OF TRAINING: AUG. 11, 1989

ANSWERS TO OPEN-ENDED EVALUATION QUESTIONS

How will your practice change as a result of what you learned today?

More awareness.

I will be much more aware of what to look for.

I now know what to look for.

Greater understanding of how APS works.

More awareness and specific ideas of how to deal with situations.

More knowledge on elder abuse.

More sensitive to elder abuse issues, more observant of possible abuse, know common resources.

What information do you feel you did not get in this session?

I would have liked more information about who are the abused/abusers very early on in the first session, instead of one hour into the talk.

More video of abuser and abused, how they think and act.

Added comments:

Having local APS people talk was a fabulous idea.

SHORT-TERM TRAINING ON ELDER ABUSE FOR PHYSICIANS

PROGRAM EVALUATION RESULTS

SEPTEMBER 9, 1989

SHORT TERM TRAINING ON ELDER ABUSE FOR PHYSICIANS

PROGRAM EVALUATION RESULTS

SESSION DATE: SEPTEMBER 9, 1989

EVALUATION TOPIC:	FREQUENCY OF RESPONSES: POOR 1	FAIR 2	GOOD 3	VERY GOOD 4	EXCELLENT 5	NO RESPONSE -9	AVERAGE SCORE SCALE OF 1 TO 5
OVERALL, THE SESSION WAS:	0	0	0	1	0	0	4.00
INTRODUCTORY LECTURE WAS:	0	0	0	1	0	0	4.00
INTRODUCTORY SLIDES WERE:	0	0	0	1	0	0	4.00
CLINICAL DIAGNOSIS LECTURE WAS:	0	0	0	0	0	1	ERR
CLINICAL DIAGNOSIS VIDEOTAPE WAS:	0	0	1	0	0	0	3.00
CLINICAL DIAGNOSIS SLIDES WERE:	0	0	1	0	0	0	3.00
LEGAL ISSUES LECTURE WAS:	0	0	0	0	0	1	ERR
LEGAL ISSUES VIDEOTAPE WAS:	0	0	0	0	0	1	ERR
CASE MANAGEMENT LECTURE WAS:	0	0	0	0	0	1	ERR
CASE MANAGEMENT VIDEOTAPE WAS:	0	0	0	0	0	1	ERR
QUESTION AND ANSWER SESSION WAS:	0	0	0	0	0	1	ERR

To what extent will your practice change because of what you learned today?

	1	2	3	4	5	
NOT AT ALL	0	0	1	0	0	VERY MUCH
	0%	0%	100%	0%	0%	

Where did you hear about this training program?

	FREQ.	PCT.
BROCHURE	1	100%
THROUGH HOSPITAL	0	0%
MEDICAL JOURNAL	0	0%
ANOTHER PHYSICIAN	0	0%
ANOTHER HEALTH CARE PROFESSIONAL	0	0%
OTHER MEDIA	0	0%
OTHER	0	0%

SHORT-TERM TRAINING ON ELDER ABUSE FOR PHYSICIANS

PROGRAM EVALUATION RESULTS

SEPTEMBER 21, 1989

SHORT TERM TRAINING ON ELDER ABUSE FOR PHYSICIANS

PROGRAM EVALUATION RESULTS

SESSION DATE: SEPTEMBER 21, 1989

EVALUATION TOPIC:	FREQUENCY OF RESPONSES: POOR 1	FAIR 2	GOOD 3	VERY GOOD 4	EXCELLENT 5	NO RESPONSE -9	AVERAGE SCORE SCALE OF 1 TO 5
OVERALL, THE SESSION WAS:	0	0	0	13	4	4	4.24
INTRODUCTORY LECTURE WAS:	0	0	0	14	6	1	4.30
INTRODUCTORY SLIDES WERE:	0	2	4	12	2	1	3.70
CLINICAL DIAGNOSIS LECTURE WAS:	0	0	2	10	5	4	4.18
CLINICAL DIAGNOSIS VIDEOTAPE WAS:	0	2	3	12	2	2	3.74
CLINICAL DIAGNOSIS SLIDES WERE:	0	1	3	13	2	2	3.84
LEGAL ISSUES LECTURE WAS:	0	0	0	6	12	3	4.67
LEGAL ISSUES VIDEOTAPE WAS:	0	2	7	4	3	5	3.50
CASE MANAGEMENT LECTURE WAS:	0	0	3	12	3	3	4.00
CASE MANAGEMENT VIDEOTAPE WAS:	0	0	5	9	1	6	3.73
QUESTION AND ANSWER SESSION WAS:	0	0	1	12	2	6	4.07

To what extent will your practice change because of what you learned today?

	1	2	3	4	5	
NOT AT ALL	1	1	4	6	4	VERY MUCH
	6%	6%	25%	38%	25%	

Where did you hear about this training program?

	FREQ.	PCT.
BROCHURE	7	35%
THROUGH HOSPITAL	5	25%
MEDICAL JOURNAL	1	5%
ANOTHER PHYSICIAN	0	0%
ANOTHER HEALTH CARE PROFESSIONAL	2	10%
OTHER MEDIA	0	0%
OTHER	5	25%

SHORT-TERM TRAINING ON ELDER ABUSE FOR PHYSICIANS
PROGRAM EVALUATION FORM

DATE OF TRAINING: SEPTEMBER 21, 1989

ANSWERS TO OPEN-ENDED EVALUATION QUESTIONS

How will your practice change as a result of what you learned today?

Be more observant of routine contacts looking for abuse.

More observant.

As a EM department physician, I will be more alert for signs of elder abuse and I will be more likely to initiate DSS investigations.

More aware of legal issues.

I will report suspected abuse/neglect cases.

Interdisciplinary input of conference was helpful regarding "shared rsponsibility" in this difficult material.

It will help me as a medical consultant in home care for the Visiting Nurse Association of Southwestern Michigan.

I am not a physician, but a clinical risk specialist. Plan to offer information to hospital affiliates through risk management.

Educate other staff more, be more prone to report quicker.

To be more aware of family system concern and keeping victim in home if possible.

More alert to possibility of elder abuse, better idea of how to inquire about same.

More aware of problems and look further.

I am a BSW interested in this subject.

I will urge others and myself to be more observant and take action when needed.

More coordination with physicians.

What information do you feel you did not get in this session?

It was very thorough.

This session was very informative. It confirmed and reinforced what we have been doing in practice in most part.

More nursing home/employer abuse issues.

Actual use of assessment tools provided.

Added comments:

I would like to see the development of a shorter, simpler survey to look for high risk patients in emergency departments.

Dr. O'Brien's lecture should have contained the medical portion of Sue Haviland's presentation, (e.g., DRG's, short term management). I think that doctors would prefer to hear about medical practices from doctors.

Excellent conference. Something similar would be useful for our DSS caseworkers.

Dr. O'Brien's videotape: edit first and third parts (attending and resident talking) to shorten them. To me, these parts were ponderous and could be shortened without losing anything important.

A conference for physicians was a long time in coming.

SHORT TERM TRAINING ON ELDER ABUSE FOR PHYSICIANS

PROGRAM EVALUATION RESULTS

NOVEMBER 29, 1989

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SHORT TERM TRAINING ON ELDER ABUSE FOR PHYSICIANS

PROGRAM EVALUATION RESULTS

SESSION DATE: NOVEMBER 29, 1989

EVALUATION TOPIC:	FREQUENCY OF RESPONSES: POOR (1)	FAIR (2)	GOOD (3)	V. GOOD (4)	EXCELLENT (5)	NO RESPONSE	AVERAGE SCORE SCALE OF 1 TO 5
OVERALL THE PROGRAM WAS:	0	0	2	6	2	0	4.00
INTRODUCTORY LECTURE WAS:	0	0	1	7	2	1	4.10
INTRODUCTORY SLIDES WERE:	0	0	1	7	2	1	4.10
CLINICAL DIAGNOSIS LECTURE WAS:	0	0	4	6	1	0	3.73
CLINICAL CIAGNOSIS VIDEOTAPE WAS:	0	1	4	3	3	0	3.73
CLINICAL DIAGNOSIS SLIDES WERE:	0	0	2	8	1	0	3.91
LEGAL ISSUES LECTURE WAS:	0	1	2	4	3	1	3.90
LEGAL ISSUES VIDEOTAPE WAS:	0	0	5	4	1	1	3.60
CASE MANAGEMENT LECTURE WAS:	0	0	2	6	1	2	3.89
CASE MANAGEMENT VIDEOTAPE WAS:	1	0	1	4	1	4	3.57
QUESTION AND ANSWER SESSION WAS:	0	0	3	3	1	4	3.71

To what extent will your practice change because of what you learned today?

	1	2	3	4	5	
NOT AT ALL	0	0	3	6	2	VERY MUCH
	0%	0%	27%	55%	18%	

Where did you hear about this training program?

	FREQ.	PCT.
BROCHURE	7	54%
THROUGH HOSPITAL	0	0%
MEDICAL JOURNAL	0	0%
ANOTHER PHYSICIAN	0	0%
ANOTHER HEALTH CARE PROFESSIONAL	1	8%
OTHER MEDIA	2	15%

WHERE DID YOU HEAR ABOUT THIS TRAINING PROGRAM?

Health Care Weekly Review.

Planning Group.

Health Care News.

Melanie Hwalek.

Wayne County DSS - Central Adult Medical District.

HOW WILL YOUR PRACTICE CHANGE AS A RESULT OF WHAT YOU LEARNED TODAY?

I will be more alert, to find out about Elder Abuse.

I was pretty much tuned into these issues pre-workshop.

SIGNIFICANTLY, in the sense that this conference has brought awareness to the problem of Elder Abuse.

More awareness of Elder Abuse and more knowledge.

More awareness.

I think I will report some neglectful care I have seen from nursing homes to the Public Health Department.

More alert to indicators of possible abuse/neglect.

Better utilize services available (understanding what each agency role is, is critical to good coordinating of services).

WHAT INFORMATION DO YOU FEEL YOU DID NOT GET IN THIS SESSION?

Good overview (excellent in fact) of a timely topic. Need to package for use in CME and physician education settings.

None.

Mental status evaluation and depression screen referred to by Dr. O'Brien would have been good to have in information package.

N/A.

PLEASE ADD ANY OTHER COMMENTS ON THE BACK OF THIS FORM. THANK YOU.

What a great conference! Timely topic, excellent/knowledgeable speakers. Very good handouts. Thanks for the bibliography. Good Lunch! Somehow-someway this needs broader dissemination: Too many persons simply don't know about the law. Only one criticism, conference PR was very low profile. Physicians, I believe, were more likely than not to never have been aware. Should have made special effort to involve physicians-in-training.

These lectures should have <u>all</u> been shortened considerably. The Q&A sessions should have been lengthened.

APPENDIX E:

Plans for Dissemination of
Lectures, Slides, Videotapes Developed for the
Michigan Physicians' Conference on Elder Abuse

Item 1: Outline of Program for Dissemination

Item 2: Advertising Brochure

ASSESSMENT AND MANAGEMENT OF ELDER ABUSE: A Program for Primary Care Physicians

Module (Unit or Session)	Learning Objectives	Instructional Strategies	Instructional Materials
1	1. Incorporate screening and identification of abuse into regular clinical encounters with elderly patients.		
	a Explain why primary care physicians have a unique opportunity to identify and assess elder abuse.	Lecturette (content from Mary Cay)	Handout Visuals (Overhead transparencies)
	b. Define and distinguish between psychological neglect, psychological abuse, violation of personal rights, financial/material abuse, physical neglect, and physical abuse.	Lecturette (content from Mary Cay)	Handout Visuals
2	c. Identify patients at high risk for abuse by family members or others.	Lecturette (Sengstock stuff from O'Brien's lecture) & Video vignette (Kursch & Thiede talk)	Handout Visuals Videotape
3	d. Identify common clinical features (symptoms, signs and other indicators) of physical abuse and neglect.	Slides and discussion (from O'Brien lecture)	Slides Handout (content plus a worksheet)
4	2. Describe appropriate and inappropriate ways to approach elder abuse victims and perpetrators.	Lecturette (from Leon & O'Brien lectures)	Handout Visuals
	a victim interview	Video vignette (Kursch's patient interview); Group discussion	Videotape with observation checklist
	b. interview with potential abuser	Video vignettes (Mick/Dr.Craig); Group discussion	Videotape with observation checklist

5	3. Discuss legal requirements related to reporting suspected and/or actual abuse. a. Adult Protective Services reporting b. Risk of lawsuits (confidentiality and good faith reporting issues) c. What happens with report	Video vignettes (Drs. Craig & O'Brien, then w/ Tom Trainer) Group discussion of content shown in vignettes.	Videotape Handout
6	4. List major factors associated with elder abuse.	Lecturette Presentation of GAC cases;group discussion of each case—directed toward factors	Handout Visuals Worksheet on Family System Assessment Paper cases
7	5. Discuss management principles to address abuse situations. a. Recognize APS referral as a *helping* intervention, rather than adversarial. b. Identify areas of agreement between patient and caregiver/abuser needs. c. Identify physician's role and responsibility. d. Describe roles of other professionals (nurse, social worker, others) e. Identify sources of support (collaborate with other human service providers as needed).	Lecturette Presentation of GAC cases;group discussion of each case—directed toward the 5 principles	Handout Visuals Paper case with worksheet (questions about each of the 5 principles)

8	6. Describe case management strategies appropriate for abuse situations: a Short-term management: -Hospitalization (diagnosis, treatment, documentation, Medicare reimbursement requirements; working *with* Utilization Review) -Other ways to separate victim and abuser -In-home protection/assistance b. Long-term management: -Counselling -Monitoring	Lecturette (from Sue's lecture; use cases from above + other examples to illustrate points)	Handout Visuals

GERIATRIC EDUCATIONAL MATERIALS

FOR USE BY MEDICAL FACULTY

Michigan State University
Office of Medical Education Research and Development

PRODUCTS IN DEVELOPMENT

Elder Abuse Assessment & Management for the Primary Care Physician

by James O'Brien, MD, Mary C. Sengstock, PhD, Sue Haviland, MSN, Tom Trainer, JD, Therese deSpelder

The program is intended to help residents, students and practicing physicians incorporate screening and identification of abuse into regular clinical encounters, effectively approach abuse victims and perpetrators, report suspected and actual cases of abuse, and implement appropriate management strategies for abuse cases. Eight teaching modules address types of abuse and neglect, common clinical signs, patients and families at risk, interviewing skills, and case management principles and strategies.

Contents: Videocassette, Program Manual with master handouts, suggested agenda and teaching strategies, slides and overhead transparencies.

Home Care Curriculum for Family Practice Residents

by Karen Ogle, MD, Laura Dwyer, MSc, Kay Thiede, MSN, Karen W. Lienhart, MA

The program goal is to influence residents to value home health care and be able to implement home care in future practice. Topics include Clinical Concepts and Skills (community resources, family caregivers, communication, technology, functional assessment, rehabilitation, specific clinical topics and dying at home) and Administration/ Practice Management issues (team concepts and cost reimbursement). The model is being implemented and field tested in the MSU/St. Lawrence Hospital Family Practice Residency Program.

Content: Materials designed to be integrated with a geriatrics rotation and longitudinal care of patients in their homes: core readings, annotated references to other reading material, plans for home care and community agency experiences, worksheets to analyze experiences, evaluation strategies, home care implementation guides for future practice.

Packages available: October 1990
For more information, contact: Karen W. Lienhart, MA
OMERAD, Phone 517-353-9656

APPENDIX F:

List of Other Materials

Distributed in Attendees' Packet

1.+ Pamphlet on "Adult Protective Services" Public Act 519 for Physicians

2.+ Pamphlet: "Adult Protective Services in Michigan"

3.+ Pamphlet: "Adult Protective Services Program"

4.+ Pamphlet: "Law Enforcement Agency Coordination with Michigan Department of Social Services"

5.+ Pamphlet on Service Programs from Area Agencies on Aging

6.+ Hwalek-Sengstock "Elder Abuse Screening Test" ("EAST"), 1986

7.* Sengstock-Hwalek Comprehensive Index of Elder Abuse (1986a)

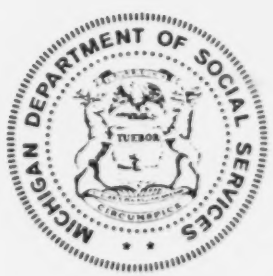
8.* Instruction Manual for Sengstock-Hwalek Comprehensive Index of Elder Abuse (1986b)

+ See attached.

* For copies, contact: SPEC Associates
30400 Telegraph (#327)
Birmingham, MI 48010
(313) 647-8444

ADULT PROTECTIVE SERVICES

As Required By
Act No. 519
Public Acts 1982
and
Public Act 208
of 1987



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DSS Publication 683 (6-89)

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LANSING, MI 48909

• IMPORTANT INFORMATION FOR PHYSICIANS ON HOW TO MAKE **ADULT PROTECTIVE SERVICES** REFERRALS

Re: Adult Protective Services (APS)
Reporting abuse, neglect, exploitation
and endangerment

Dear Physician:

On December 19, 1987 Governor James Blanchard signed into law HB4094 (Public Act 208 of 1987).* This bill now has the effect of requiring a physician who suspects that a vulnerable adult has been abused, neglected, exploited or endangered to make an oral report to the county department of social services located in the county where the incident took place. After making the oral report, the person may file a written report with the county department. The responsibility of physicians to report is now identical to the responsibility of other individuals identified in previous legislation.

It is important to understand what to report as well as how to report. The law is quite specific that an "adult in need of protective services" or "adult" means: 1) "a vulnerable person, 2) not less than 18 years of age who is, 3) suspected of being abused, neglected, exploited or endangered." All three elements must be present for an adult to be considered in need of protective services. Definitions of these terms are given in this letter. In the event there is a question as to the meaning of any of these terms , you may discuss the situation with an adult protective services worker in your county DSS office.

All Adult Protective Service reports are required to contain the name of the adult and a description of the harm that was done. If possible the report shall contain the adult's age and the name and addresses of the adult's guardian or next of kin, and of the persons with whom the adult resides, including their relationship to the adult. The report shall contain other information available to the physician which may help establish the cause of the abuse, neglect, exploitation or endangerment and the manner in which it occurred.

(OVER)

*The complete Adult Protective Services Act is contained in Act 519, P.A. 1982 and Public Act 208, of 1987, or the Michigan Compiled Laws 400.11.

BEST COPY AVAILABLE

Upon receipt of the report, the APS worker will commence an investigation within twenty-four hours. Part of the investigation will determine if the adult wants protective services. The county APS worker will make available to the adult the most appropriate and least restrictive protective services and take action to safeguard and enhance the welfare of the adult. There may be occasions when the worker will collaborate with law enforcement officers, courts of competent jurisdiction and appropriate state and community agencies. The results of the investigation are confidential and are not routinely shared with the reporting person.

A report made by a physician or other licensed health professional pursuant to this act shall not be considered a violation of any legally recognized privileged communication nor is a report the same as an allegation. Further, the identity of a person making a report shall be confidential subject only to disclosure with the consent of that person or by judicial process.

You as a physician are encouraged to discuss the APS program with county DSS/APS personnel and contribute your thinking on how the program can be more efficient and helpful to the adults who need protective services and the persons who make reports.

Sincerely,

C. Patrick Babcock

DEFINITIONS

SECTION 11. As used in this section and sections 11a to 11f:

(a) "Abuse" means harm or threatened harm to an adult's health or welfare caused by another person. Abuse includes nonaccidental physical or mental injury, sexual abuse, or maltreatment.

(b) "Adult in need of protective services" or "adult" means a vulnerable person not less than 18 years of age who is suspected of being abused, neglected, exploited, or endangered.

(c) "Endangered" or "endangerment" means a life threatening situation caused by the inability of the person whose life is threatened to respond.

(d) "Exploitation" means an action which involves the misuse of an adult's funds, property, or personal dignity by another person.

(e) "Neglect" means harm to an adult's health or welfare caused by the conduct of a person responsible for the adult's health or welfare. Neglect includes the failure to provide adequate food, clothing, shelter, or medical care. A person shall not be considered to be abused, neglected, or in need of emergency or protective services for the sole reason that the person is receiving or relying upon treatment by spiritual means through prayer alone in accordance with the tenets and practices of a recognized church or religious denomination, and this act shall not require any medical care or treatment in contravention of the stated or implied objection of that person.

(f) "Protective services" includes, but is not limited to, remedial, social, legal, health, mental health, and referral services provided in response to a report of alleged harm or threatened harm because of abuse, neglect, exploitation, or endangerment.

(g) "Vulnerable" means a condition in which an adult is unable to protect himself or herself from abuse, neglect, exploitation, or endangerment because of a mental or physical impairment or because of the frailties or dependencies brought about by advanced age.

ADULT PROTECTIVE SERVICES IN MICHIGAN

MICHIGAN
DEPARTMENT
OF
SOCIAL SERVICES

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INTRODUCTION

Maltreatment of adults in general has become a serious nationwide problem. In addition, the number of endangered aged and handicapped adults is steadily increasing. Several states have responded to this problem by enacting legislation to protect adults from such harm. Michigan lawmakers have responded by enacting the "Adult Protective Services Act", Public Act 519, which went into effect April 1, 1983. This act requires the Department of Social Services to provide protective services to adults. It also requires certain persons in the community to report suspected cases to the Department.

This booklet is designed to inform the general public, social services agencies, community organizations and interested individuals about the Department's Adult Protective Services Program. It explains what protective services are, who is eligible to receive services, what services are available and how a referral can be made.

Hopefully, those who read this booklet will benefit by seeking help when needed, whether it be for themselves or others in their community who may be in need. By bringing information on adult protective services to the public's attention, the Department will move closer to reaching its goal of alleviating the problem of maltreatment of adults in Michigan.

ADULT PROTECTIVE SERVICES IN MICHIGAN

LEGAL RESPONSIBILITY

Public Act 519 gives the Department of Social Services the responsibility to provide adult protective services to those in need who require this help. This law requires the Department of Social Services to "commence an investigation to determine whether the person suspected of being abused, neglected, exploited or endangered is an adult in need of protective services". Based upon the findings of the investigation, the Department is to "make available to the adult the appropriate and least restrictive protective services . . . , and take necessary action to safeguard and enhance the welfare of the adult, if possible."

DEFINITIONS

The following are definitions for terms the Department and other agencies/individuals use in the course of carrying out the law.

- **Protective Services** – includes, but is not limited to, remedial, social, legal, health, mental health, and referral services provided in response to a report of alleged harm or threatened harm because of abuse, neglect, exploitation, or endangerment.

- **Abuse** – any harm or threatened harm to an adult's health or welfare caused by another person. This includes nonaccidental physical injury, mental injury, sexual abuse, or maltreatment. An example of abuse is:

  A retarded woman who resides in the home of her father is being beaten by him.

- **Neglect** – any harm to an adult's health or welfare caused by the conduct of a person responsible for the adult's care. This includes failure to provide adequate food, clothing, shelter or medical care. Self-neglect is also included. An example:

  A mentally impaired man is left in front of the T.V. all day without a meal or other provisions; or a physically disabled person living at home alone is suffering from malnutrition because s/he is unable to shop or prepare adequate meals.

- **Exploitation** – any action which involves the misuse of an adult's funds, property, or personal dignity by another person. An example of exploitation:

  An aged woman's adult son who is her representative payee is using her money for his own needs without her knowledge or approval.

- **Endangerment** – a life threatening situation caused by the inability of the person whose life is threatened to respond. An example of endangerment is:

  An aged person living alone whose health is deteriorating and whose heat has been shut off.

- **Vulnerable** – a condition in which an adult is unable to protect himself or herself from abuse, neglect, exploitation or endangerment because of a mental or physical impairment or because of the frailties or dependencies brought about by advanced age.

CHARACTERISTICS OF INDIVIDUALS NEEDING PROTECTIVE SERVICES

Adults in need of adult protective services have frequently been found to have one or more of these characteristics:

- Aged, developmentally disabled or severely physically disabled.
- Living alone.
- Frequently depressed.
- Withdrawn from social activities and interaction.
- Without close relatives or friends willing and able to provide needed assistance.
- Often somewhat confused and not able to provide for their own care.
- Having increasing problems in taking care of own needs or dealing with others.
- May well have attempted to commit suicide or at least considered it.

REFERRALS FOR ADULT PROTECTIVE SERVICES

The need for a protective services investigation is indicated when there is reason to belive an adult is actually in danger of harm due to the presence or threat of any of the following:

- Abuse
- Neglect
- Exploitation, or
- Endangerment

Any person, whether relative, friend, or concerned person, can make a request for protective services on an individual's behalf.

MANDATED REPORTING

Certain persons are required by 1982 P.A. 519 to report suspected abuse, neglect, exploitation, or endangerment of adults to the Department. Those required to report are:

1. Those employed, licensed, registered, or certified to provide:
   a) health care
   b) education services
   c) social welfare services
   d) mental health services
   e) other human services
2. An employee of an agency licensed to provide:
   a) health care
   b) education services
   c) social welfare services
   d) mental health services
   e) other human services
3. Law enforcement officer.
4. Employee of county medical examiner.
5. Physician, who in his/her professional judgment suspects abuse, neglect, exploitation, or endangerment and who believes that reporting is in the best interest of the adult.

Per 1982 P.A. 519 the reporting person is required to give the following information:

1. Name of the adult.
2. Description of the abuse, neglect, exploitation, or endangerment.
3. Other information available to the reporting person on the cause and manner of the abuse, neglect, exploitation, or endangerment.
4. If available:
   a) the adult's age
   b) the identity and the address of the guardian or next of kin
   c) the identity, the address, and the relationship of those with whom the adult resides.

EXCLUDED SETTINGS

Certain residential facilities are already covered by legislation which requires other state agencies to investigate and resolve situations which involve endangered adults. For example, the Department of Public Health is responsible to investigate complaints which allege the abuse or neglect of patients in nursing homes and hospitals or residents of homes for the aged. The Department of Mental Health also has a system set up to conduct investigations in the state operated psychiatric hospitals and developmental disability centers. Public Act 519 seeks to avoid duplication of effort by state agencies by excluding the Department of Social Services from conducting investigations in those facilities which are either licensed by the Department of Public Health or are funded and operated by the State of Michigan, such as educational centers, correctional facilities and mental health institutions and centers.

All suspected cases or incidents of a protective services nature involving a resident of such facilities are the legal responsibility of other state agencies and should be referred to the appropriate authorities and not to the Department of Social Services.

RESPONSIBILITY OF THE ADULT PROTECTIVE SERVICES WORKER

SOCIAL INTERVENTION

- Investigating reports of alleged abuse, neglect, and exploitation.
- Pleading the person's cause with agencies or officials.

- Getting needed medical care and arranging for payment.
- Providing or arranging for instruction in the use of financial resources.
- Assisting in making formal fiscal arrangements for protective management of resources, short of legal guardianship. This includes assistance in arranging for social security or Supplemental Security Income representative payees, power of attorney, or trust arrangements.
- Finding suitable housing.
- Seeking legal assistance.
- Contacting neighbors, relatives, or friends to evaluate the circumstances and enlist their help if appropriate.
- Arranging for aged, blind, and disabled individuals to receive help with necessary unskilled daily activities which they cannot perform without assistance.
- Continuing to stay in personal contact with the individual, giving needed help until the danger is removed, controlled or other arrangements have been made for protection.

LEGAL INTERVENTION

Sometimes protective services are requested for those who do not want services. The individual's "right of choice" must be considered. However, if in the worker's best judgment, serious harm appears imminent to the individual(s) at risk or others, the worker may petition the court to make a determination as to the individual's capacity to make a decision. A court petition should be filed only as a last resort in providing protective services. Only the court has the power to determine if the individual is legally incapacitated and thus unable to make responsible decisions regarding choices affecting his/her life. The person having the first-hand knowledge of the situation is the preferred agent to seek legal action, however, when such a person is not available the worker is to secure legal services.

Legal actions may include:

- Petitioning the Probate Court for a conservatorship and/or guardianship determination when the worker's assessment indicates a person may not be competent.
- Petitioning the Probate Court for civil admissions under the Mental Health Code, P.A. 258 of 1974.
- Other specific, limited activities permitted by the court or other agency.

PROBLEMS ADULT PROTECTIVE SERVICES WORKERS FACE

Problems protective services workers face include:

- Individuals often do not know, do not want, or will not acknowledge they need help.
- Others often want "something done about a person" in need of help but refuse to be identified or will not testify as to what they witnessed.
- Behavior considered "different" or "strange" is often not tolerated by the public even though the behavior is fully within an individual's legal rights.
- Emergency shelter facilities are limited in number.
- Sufficient teams of professionals to perform medical, social, and psychiatric evaluations are often unavailable to staff working with vulnerable adults. This resource is essential to resolve existing problems, as well as planning for the future well-being of the adult population at risk.
- Inability to get needed medical and legal services on an emergency basis.
- Insufficient community resources, such as transportation.
- Shortage of preventive services to reduce the sources of endangerment.
- Lack of community awareness of the problem of vulnerable adults.

RESOURCES AVAILABLE TO THE ADULT PROTECTIVE SERVICES WORKER

Maximum coordination and cooperation are needed between all available resources including:

- Other services and programs within the Department; especially home help (chore services) and community placement. Other important programs are:

  Medical Assistance
  General Assistance
  Food Stamps
  Emergency Needs Program

- Public health and community mental health services.
- Organizations established to assist the developmentally disabled, such as Michigan Association for Retarded Citizens (MARC).
- Law enforcement agencies and courts.
- Volunteer agencies, services clubs, and other community groups such as churches.
- Organizations established to assist the physically disabled.
- Organizations established to advocate for persons living in alternative living arrangements (adult foster homes, nursing homes, homes for the aged) such as Citizens for Better Care.
- Social Security Administration.
- Regulatory agencies established to license and monitor various professions and the settings in which they practice.
- Legal aid services and advocacy groups.
- Hospitals, and other health care providers.
- Agencies providing services to the elderly.

Each local office of the Department of Social Services is encouraged to develop and institute a plan for delivery of adult protective services in collaboration with relevant community groups and individuals. This plan is to reflect the resources and deficiencies of the community it serves for the purpose of increasing and improving these services.

In addition, each local office of the Department of Social Services has developed a plan for after-hour emergencies related to protective services for adults.

ELIGIBILITY
AND HOW TO APPLY

Any person 18 years of age or over is eligible for adult protective services regardless of income.

To apply for protective services or to obtain any additional information, contact your local Department of Social Services Office.

To make a report or to get further information about the Adult Protective Services Program, contact your local Department of Social Services Office listed below or look in the white pages of your local telephone directory.

MICHIGAN DEPARTMENT OF SOCIAL SERVICES

The Department of Social Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, handicap, or political beliefs.

DSS Publication 2 (Rev. 9-83)
Previous edition obsolete.

CHARACTERISTICS OF THOSE SERVED

Adults most likely to need protective services are often:

- Elderly, especially if living alone
- Developmentally disabled or severely physically disabled
- Without close relatives or friends willing or able to assist
- Confused or depressed and not capable of caring for their own basic needs
- Withdrawn from social activities and interaction.

DEVELOPING A CARING COMMUNITY

A caring community is made up of individuals who are aware of the needs of the vulnerable adult. These citizens accept the responsibility to notify the Department of Social Services when they find a person in need of protection.

Do you know of anyone you think may need adult protective services? If so, contact the Department of Social Services. You do not have to give your name when reporting.

ELIGIBILITY

All persons requiring assistance are provided services based upon **need** only. There are no other eligibility requirements.

To make a report or to get further information about the Adult Protective Services Program, contact your local Department of Social Services office listed below or look in the white pages of your local telephone directory.

MICHIGAN DEPARTMENT
OF SOCIAL SERVICES

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DSS Publication 5 (Rev. 9-83)
(Previous edition obsolete.)

ADULT PROTECTIVE SERVICES PROGRAM

MICHIGAN DEPARTMENT OF SOCIAL SERVICES

ADULT PROTECTIVE SERVICES

Michigan Department of Social Services

Not being able to deal with a threatening situation is scary to everyone. The aim of the Adult Protective Services Program is to reduce this fear by assisting those persons 18 years old or older who have been abused, neglected, exploited or endangered and who are unable to take the necessary steps to correct their situation.

Abuse is harm or threatened harm to an adult's health or welfare caused by another person. An example of abuse is:

- A retarded woman, who resides in the home of her father, and is being beaten by him.

Neglect is harm to an adult's health or welfare caused by the conduct of a person responsible for the adult's health or welfare. An example of this is:

- A physically and mentally disabled man is left in front of the T.V. all day without a meal or other necessary provisions.

Exploitation is the misuse of an adult's funds, property, or personal dignity by another person. An example of exploitation:

- An elderly woman's adult son is using her money for his own needs without her knowledge or approval.

Endangerment is a life threatening situation caused by the inability of the person whose life is threatened to respond. An example is:

- An aged person living alone whose health is deteriorating and whose heat has been shut off.

LEGAL RESPONSIBILITY

Public Act 519 gives the Department of Social Services the responsibility to provide adult protective services to those in need who require this help. This law requires the Department of Social Services to "commence an investigation to determine whether the person suspected of being abused, neglected, exploited or endangered is an adult in need of protective services". Based upon the findings of the investigation, the Department is to "make available to the adult the appropriate and least restrictive protective services . . . , and take necessary action to safeguard and enhance the welfare of the adult, if possible."

SERVICES PROVIDED FOR ADULTS

Services provided through adult protective services are varied. They are geared toward responding to the array of problems experienced by those adults in need of protection. The Adult Protective Services Program provides the following services:

- Protection
  - Protective Services Investigation
  - Social Protection
  - Financial Management
  - Conservatorship/Guardianship/Civil Commitment
- Case Management
- Counseling
- Education and Training
- Family Planning
- Health Related
- Home Help
- Homemaking
- Housing
- Information and Referral
- Money Management
- Volunteer Services

Protective services include services directed toward the goal of protection. Services are provided to help adults who are at risk of harm so they can deal with problems they are facing.

Complete Below for Your Jurisdiction

COUNTY ADULT PROTECTIVE SERVICES UNIT

EMERGENCY 24-HOUR CONTACT NUMBER AND PROCEDURES

MICHIGAN
DEPARTMENT OF SOCIAL SERVICES

The Department of Social Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, handicap, or political beliefs.

DSS Publication 561 (10-84)

LAW ENFORCEMENT AGENCY COORDINATION WITH MICHIGAN DEPARTMENT OF SOCIAL SERVICES

ADULT PROTECTIVE SERVICES

INTRODUCTION

This pamphlet, with minor technical changes by the Bureau of Adult Services, Michigan Department of Social Services, was developed as a training bulletin for law enforcement officers by Officer Steven R. Kelly of the Marshall Police Department, Marshall, Michigan, with the assistance of Paul Hayhow, Adult Services Supervisor, Calhoun County Department of Social Services. Its intent is to provide police personnel with information in responding to situations involving adults who are at risk of harm and who are vulnerable.

The training bulletin was submitted to the Law Enforcement Officers' Training Council, Michigan Department of State Police, with the intent that it be used in the Council's ongoing statewide training program. The Council is responsible for setting standards and establishing guidelines for the training of law enforcement officers in Michigan. The Council endorsed the bulletin and forwarded it to all regional training academies in the state for their use in training. While it is not a core component of training, as is for example, training in the use of hand guns, increasing use of the material is expected. As Department of Social Services local offices coordinate Adult Protective Services programs with law enforcement agencies, this bulletin may be helpful as a guide to facilitate communication and clarify respective roles.

ADULT PROTECTIVE SERVICES REFERRALS

As a part of their law enforcement duties, police officers may be requested to check on the welfare of an adult. Upon investigation, the officer may find that the adult is not able to adequately provide for their own personal care, and is in immediate danger. The adult may be vulnerable due to physical or mental disability, or frailties or dependencies brought about by advanced age.

Act 519, P.A. 1982, provides for referral of vulnerable adults in endangered circumstances to the Adult Protective Services Program, of the Department of Social Services. The law makes reporting by some professionals, including police officers, mandatory. The Statute further provides for investigation and assistance to these adults by the Michigan Department of Social Services.

While the peace officer cannot take an adult into protective custody with the same authority as in other situations such as mental illness or child abuse, the officer can make a referral to Michigan Department of Social Services, Adult Protective Services Unit for investigation by that department. In cases involving an adult in immediate danger, procedures exist for 24-hour emergency referral, consultation, and possible placement in a temporary facility pending an investigation by adult protective service workers.

The officer should make an emergency referral to Adult Protective Services if it is believed that the adult is (1) in immediate danger, and (2) is unable to adequately meet the source of endangerment due to apparent physical or intellectual impairment. If the adult appears to be physically or intellectually impaired to the extent that the adult is not able to adequately intervene for their own self-protection, but is not in immediate peril, a referral should be made to the Department of Social Services during the next working day.

When considering a referral to the Department of Social Services, the following factors should be assessed:

1. **PHYSICAL IMPAIRMENT**

   The subject shows visible handicaps or injuries, a lack of ability to move about their dwelling, and other signs which indicate to the officer that the person is apparently suffering from substantial physical disability which significantly impairs their ability to perform ordinary activities of daily living.

2. **INTELLECTUAL IMPAIRMENT**

   Although not appearing mentally ill, and therefore in need of peace officer's certification and transportation to the Regional Psychiatric Hospital, the individual illustrates through verbal interaction an inability to adequately understand current circumstances and existing endangerment.

3. **DANGEROUS OR HARMFUL SETTING**

   In addition to arriving at a judgment that the adult is, due to physical or intellectual impairment, unable to effectively act on their own behalf, the officer must actually observe that the setting is significantly life threatening so that if the individual is not referred to Protective Services, the subject will be at risk of serious harm.

FIELD CONTACT

The officer should atempt to obtain identification from the subject and the names of any relatives that live in the area. If the subject appears to have been injured, emergency medical transportation response should be requested immediately. If the primary source of endangerment is another individual, i.e., abuse, neglect, exploitation, the police officer should assess the need for criminal action. The officer should also note the setting in which the subject is found. Items such as lack of heat during cold conditions, broken or unusable toilet fixtures, lack of running water or basic needs are all items that should be noted. If the subject appears to be physically or intellectually impaired and the setting is one that is immediately life threatening, as set out in the above guidelines, the officer should make contact with the on-call Adult Protective Services worker for consultation on possible emergency intervention.

CONTACT WITH ADULT PROTECTIVE SERVICES

The method for making contact with the Adult Protective Services Program after hours will vary from county to county. Usually the worker may be reached by calling the county crisis line, the juvenile detention facility, the Children's Protective Services unit, or other agencies which provide 24-hour phone service for the various social service units in the county. Each officer should determine in advance how to obtain assistance from Adult Protective Services when the office is not open.

The officer should explain their observations regarding the apparent physical condition of the subject to the on-call worker. The officer should also describe the setting in which the subject was found. If the worker agrees that the adult is in immediate danger, the agency will give direction as to how to proceed. If possible, the officer should remain on the scene until after arrival of a worker and the officers assistance is no longer needed. It should be noted that the subject's involvement and cooperation with the Adult Protective Services worker is on a voluntary basis.

If the worker believes that the situation is not one in which immediate protective services intervention is required, the officer should gather information needed for a referral report and clear the scene. The Adult Protective Services Unit may investigate the situation during the next working day to determine if any further action should be taken.

REPORT WRITING

The statute requires that a police officer immediately contact the Adult Protective Services Program whenever they suspect or have reasonable cause to believe that an adult has been abused, neglected, exploited, or is endangered. The officer should complete a written report of the incident making observations of the physical condition of the subject in the setting in which the adult was found. If the on-call worker elected not to intervene on an emergency basis, the officer should note reasons why and include them in the report. Should the subject later be found to have suffered injury, the officer can document notification to protective services and the attempt to secure immediate assistance for the subject. This should be legally sufficient to relieve the officer of later claims of liability for failure to act.

*AAA SERVICE PROGRAMS**

Case Coordination & Support

Information and Referral

Outreach

Transportation

Community
- Adult Day Care
- Congregate Meals
- Education
- Health Screening
- Home Repair
- Housing Assistance
- Legal Assistance
- Long-Term Card Ombudsman
- Senior Centers

In-Home Services
- Care Management
- Chore Services
- Homemaker
- Home-Delivered Meals
- Home Health Aides
- Friendly Visitors
- Personal Care
- Respite/Daycare

**Programs vary in local areas. Please contact your area for more information.*

No one shall be excluded from participation in any service or activity because of race, color, age, national origin or handicap, be denied the benefit of, or subject to discrimination under these programs.

AREA AGENCIES ON AGING

- were established by the Older Americans' Act.
- plan, develop, and coordinate a comprehensive service delivery system to seniors.
- act as an advocate for seniors.
- contract State & Federal monies for aging services.

This brochure prepared by:

319 West Lenawee
Lansing, Michigan 48933

and funded by
MICHIGAN

QUESTIONS OR PROBLEMS CONCERNING AGING?

AREA AGENCIES ON AGING

are
your local component
of the

AGING NETWORK

Appendix F: Item 5: Area Agencies on Aging Pamphlet

Senior
Transportation
TRANSPORTAT
SENIOR SERVICES
AVAILABLE IN MICHIGAN
Please contact your local
AREA AGENCY ON AGING
Listed inside.
REEN
MEALS

AREA AGENCY REGIONS

PLANNING AND SERVICE AREAS

Appendix F: Item 5:

Area Agencies on Aging Pamphlet

1A. Serving the cities of Detroit, Hamtramck, Highland Park, Grosse Pointe Park, Grosse Pointe Shores, Grosse Pointe Woods, Grosse Pointe Farms and Harper Woods:
Detroit Area Agency on Aging
3110 Book Building
1249 Washington Blvd.
Detroit, MI 48226
313/222-5330

1B. Serving Livingston, Macomb, Monroe, Oakland, St. Clair, and Washtenaw Counties:
Area Agency on Aging 1B
29508 Southfield Rd., Suite 100
Southfield, MI 48076
313/569-0333

1C. Serving Western & Southern Wayne County:
Senior Alliance, Inc.
3850 Second St., Suite 160
Wayne, MI 48184
313/722-2830

2. Serving Hillsdale, Jackson, & Lenawee Counties:
Region 2 Commission on Aging
P.O. Box 646
Adrian, MI 49221-0646
517/265-7881

3. Serving Barry, Branch, Calhoun, Kalamazoo, & St. Joseph Counties:
Southcentral Michigan Commission on Aging
8135 Cox's Drive, Suite 1C
Portage, MI 49002
616/327-4321

4. Serving Berrien, Cass, & VanBuren Counties:
Region 4 Area Agency on Aging
2919 Division St.
St. Joseph, MI 49085
616/983-0177

5. Serving Genesee, Lapeer, & Shiawassee Counties:
Valley Area Agency on Aging
708 Root Street, Room 110
Flint, MI 48503
313/239-7671

6. Serving Clinton, Eaton, & Ingham Counties:
Tri-County Office on Aging
500 W. Washtenaw
Lansing, MI 48933
517/483-4150

7. Serving Bay, Clare, Gladwin, Gratiot, Huron, Isabella, Midland, Saginaw, Sanilac, & Tuscola Counties:
Region 7 Area Agency on Aging
1200 N. Madison Ave.
Bay City, MI 48706
517/893-4506

8. Serving Allegan, Ionia, Kent, Lake, Mason, Mecosta, Montcalm, Newaygo, & Osceola Counties:
Area Agency on Aging of Western Mich., Inc.
Two Fountain Place, Suite 540
Grand Rapids, MI 49503
616/456-5664

9. Serving Alcona, Alpena, Arenac, Cheboygan, Crawford, Iosco, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, & Roscommon Counties:
Northeast Mich. Community Service Agency
2373 Gordon Road
Alpena, MI 49707
517/356-3474

10. Serving Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, & Wexford Counties:
Northwest Michigan Senior Resources
1609 Park Drive, P.O. Box 2010
Traverse City, MI 49685
616/947-8920

11. Serving Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, & Schoolcraft Counties:
Region 11 Area Agency on Aging
118 N. 22nd Street
Escanaba, MI 49820
906/786-4701

14. Serving Muskegon, Oceana, & Ottawa Counties:
Region 14 Council on Aging
315 W. Webster
Muskegon, MI 49440
616/722-7811

Photos Courtesy of Michigan Travel Bureau

Area Agencies on Aging • Promoting Senior Independence

HWALEK-SENGSTOCK ELDER ABUSE SCREENING TEST
("EAST")
1986

by

Melanie Hwalek, Ph.D.
President
SPEC Associates

and

Mary C. Sengstock, Ph.D., C.C.S.
Professor of Sociology
Wayne State University

NOTES ON SCORING:
A "NO" response has been found to be associated with abuse on all items marked with a "*".
On Question 5, the response "OTHER" is associated with abuse.
A "YES" response is associated with abuse on all other items.

Psychometric validation of this Protocol is incomplete.
No data are available as yet for cutoff scores.

For further information, please contact:

SOCIAL PROGRAM EVALUATORS AND CONSULTANTS, INC.
30400 Telegraph (#327)
Birmingham, MI 48010
(313) 647-8444

HWALEK-SENGSTOCK ELDER ABUSE SCREENING TEST
("EAST")
1986

I HAVE A FEW QUESTIONS THAT WE'RE ASKING EVERYONE OVER THE AGE OF 60. SOME OF THESE QUESTIONS MAY NOT SEEM TO APPLY TO YOU. BUT WE NEED THIS INFORMATION TO SEE IF WE NEED MORE SERVICES FOR OLDER PEOPLE IN THIS STATE.

1.	Do you have anyone who spends time with you taking you shopping or to the doctor?	[ ] NO	[ ] YES
2.	Are you helping to support someone?	[ ] NO	[ ] YES
* 3.	Do you have enough money to pay your bills on time?	[ ] NO	[ ] YES
4.	Are you sad or lonely often?	[ ] NO	[ ] YES
5.	Who makes decisions about your life - like how you should live or where you should live?	[ ] ELDER	[ ] OTHER
6.	Do you feel very uncomfortable with anyone in your family?	[ ] NO	[ ] YES
* 7.	Can you take your own medication and get around by yourself?	[ ] NO	[ ] YES
8.	Do you feel that nobody wants you around?	[ ] NO	[ ] YES
9.	Does anyone in your family drink a lot?	[ ] NO	[ ] YES
10.	Does someone in your family make you stay in bed or tell you you're sick when you know you're not?	[ ] NO	[ ] YES
11.	Has anyone forced you to do things you didn't want to do?	[ ] NO	[ ] YES
12.	Has anyone taken things that belong to you without your OK?	[ ] NO	[ ] YES
* 13.	Do you trust most of the people in your family?	[ ] NO	[ ] YES
14.	Does anyone ever tell you that you give them too much trouble?	[ ] NO	[ ] YES
* 15.	Do you have enough privacy at home?	[ ] NO	[ ] YES
16.	Has anyone close to you tried to hurt you or harm you recently?	[ ] NO	[ ] YES

HWALEK-SENGSTOCK ELDER ABUSE SCREENING TEST (EAST)

FACTORS DISCRIMINATING BETWEEN ABUSE/NEGLECT AND CONTROL CASES

NOTE: THESE ARE QUESTIONS ADDRESSED TO THE ELDER.
Professionals must learn to ask abuse/neglect questions:
- as part of normal intake process/professional interview
- without obvious embarrassment on part of interviewer

VARIABLES:

Elder's Feelings:
Is often sad or lonely. [4]
Feels nobody wants him/her around. [8]
Feels uncomfortable with someone in the family. [6]

Family Characteristics:
Someone drinks a lot. [9]
Someone tells stories that aren't true. [13]
Elder has trouble paying bills on time. [3]
Elder is helping to support someone. [2]
Difficult for Elder to have privacy. [15]

Elder's Treatment:
Needs help taking medication or getting around. [7]
No one to take Elder shopping or to doctor. [1]
Someone makes Elder stay in bed when s/he's not sick. [10]
Forced to do things s/he didn't want to do. [11]
Someone else makes decisions about Elder's life. [5]

Actions Against Elder:
Someone has taken Elder's things without permission. [12]
Someone tells Elder s/he's too much trouble. [14]
Someone has tried to hurt Elder. [16]

TABLE 7: CLASSIFICATION RESULTS FOR FINAL STAGE OF THE DISCRIMINANT FUNCTION ANALYSIS

		PREDICTED GROUP MEMBERSHIP:			
ACTUAL GROUP MEMBERSHIP:	NUMBER OF CASES	CONTROL No.	CONTROL %	ABUSE/NEGLECT No.	ABUSE/NEGLECT %
CONTROL	33	32	97.0	1	3.0
ABUSE/NEGLECT	44	4	9.1	40	90.9

Percent of cases correctly identified: 93.5%

[From: Melanie Hwalek and Mary C. Sengstock, "Assessing the Probability of Elder Abuse: Toward the Development of a Clinical Screening Instrument." Journal of Applied Gerontology, Vol. 5, No. 2: 153-173 (December, 1986).]